MEDICAL RELEASE FORM

Have You Ever Been Treated by a Physician for:

- ☐ Arthritis
- ☐ Chronic Fatigue Syndrome
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Gastric Reflux
- ☐ Glaucoma
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Anterior Cruciate Ligament Knee Injuries
- ☐ Facet Joint Syndrome
- ☐ Herniated or Bulging Disc
- ☐ Spondylolisthesis
- ☐ Stenosis
- ☐ Total Hip Replacement
- ☐ Orthopedic/Joint Problems
- ☐ Peripheral Neuropathy (numbness/tingling/diminished sensation)
- ☐ Other_____

Are you Pregnant? ☐ **Yes** ☐ **No** **Prior Deliveries:** _____

Prior Surgeries: _____

_____

Prior Injuries, Musculoskeletal and Neuromuscular Issues:

- ☐ Adhesive Capsulitis (frozen shoulder)
- ☐ Thoracic Outlet Syndrome
- ☐ Carpal Tunnel Syndrome
- ☐ Rotator Cuff Impingement
- ☐ Plantar Fasciitis
- ☐ Other_____

Are you currently taking medications and/or nutritional supplements?
If so, please list. ☐ **Yes** ☐ **No**

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Activity Level/Exercise Frequency: _____

Prior Movement Experience?: (dance, Feldenkrais, yoga, etc.)

_____

Signature: _____ Date:_____