Core Physical Therapy Service Waiver

I _____ hereby give my consent
(client name or parent of client if under 18 years old)
for Core Physical Therapy L.L.C. to provide the following:

Date MM DD YY

Cupping and/or "I-ASTM" (Instrument-assisted soft tissue mobilization)

Name of Service above

I understand that I may experience bruising, petechiae response, soreness, pain, bleeding, or tenderness following this service. Typically symptoms last 24-72 hours, but in rare cases they can last longer.	CHECK IF AGREE	YES ☐ NO ☐
Region of discomfort/treatment	(I.e. knee, back)	
Have you had this done before?	Yes	No / Specify
Anything Core Physical Therapy L.L.C. should know about your health?	(Conditions, surgeries, etc)	
DO YOU HAVE/USE THE FOLLOWING:		
Aspirin or Anti-coagulation/Blood thinner in your system	Check	YES ☐ NO ☐
Conditions that cause excessive inflammation?	Check	YES ☐ NO ☐
Cardian failure, renal failure, ascites, hemorrhagic diseases (allergic purpura, hemophilia, leukemia) dermatitis, hernia, cancer, hives, herpes, shingles, lives or kidney condition, varicose veins, pregnancy)	Check YES ☐ NO ☐	Explain:
Client or Parent Signature as agree all information is correct and I hereby agree to services above *Signature:* _____	Client is over 18 years old	YES ☐ NO ☐
	Parent of guardian name:	
Would you like more information for personal training and/or physical therapy from Core Physical Therapy L.L.C?	If Yes, add phone number or email for contact	

Thank you for allowing Core Physical Therapy L.L.C. to be part of your journey to health!

If you have any questions or concerns, please email tegan@coreptmn.com or call (320) 434-5024 or visit our website at coreptmn.com for more information