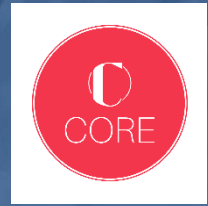


Core Physical Therapy Service Waiver



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

Explain:

YES

NO

Client or Parent Signature as agree all information is correct and I hereby agree to services above

Client is over 18 years old

YES

NO

Signature: _____

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