

CLEAN LIVING LIFESTYLES LLC

ASSISTED STRETCHING PRE-RELEASE & PAIN ASSESSMENT FORM

(Clinical Format — Based on ACSM Standards)

Practitioner Name: _____ Date: _____

1. CLIENT INFORMATION

Full Name: _____ Date of Birth: _____

Phone: _____ Email: _____

2. PURPOSE OF ASSISTED STRETCHING

The purpose of assisted stretching is to enhance flexibility, improve joint range of motion, and promote muscular relaxation through practitioner-guided techniques performed within safe limits of movement.

3. POTENTIAL RISKS AND BENEFITS

Assisted stretching is generally safe for most individuals. Minor muscle soreness or fatigue may occasionally occur. Report any discomfort immediately so adjustments can be made.

Expected benefits include:

- Improved flexibility and joint function
- Enhanced recovery and muscular relaxation
- Reduced tension and stiffness
- Support for posture and mobility

4. HEALTH SCREENING (ACSM PAR-Q)

Question	Yes	No
Has your doctor ever advised you to limit physical activity?		
Do you experience chest pain during or outside activity?		
Do you ever lose balance or consciousness?		
Do you have any joint or bone condition aggravated by movement?		
Are you currently on medication for heart or blood pressure?		
Any other medical reason you should avoid activity?		

Relevant medical conditions, injuries, or surgeries: _____

5. INFORMED CONSENT

I acknowledge that I have voluntarily chosen to participate in assisted stretching sessions provided by CLEAN

LIVING LIFESTYLES LLC. I understand the purpose, procedures, and potential minor risks. I affirm that I have disclosed all relevant health information and will communicate any pain or discomfort during a session. I understand that the practitioner is not a medical provider and does not diagnose or treat medical conditions.

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

6. PAIN & MOBILITY ASSESSMENT

Please indicate areas of pain, tightness, or limited movement below (check all that apply): ■ Neck ■ Shoulders ■ Upper Back ■ Lower Back ■ Hips ■ Hamstrings ■ Quadriceps ■ Calves ■ Ankles/Feet ■ Arms ■ Hands ■ Other: _____

Body Diagram — Mark Areas of Pain or Tightness

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1. CLIENT INFORMATION
Full Name: _____
Date of Birth: _____ Phone: _____

2. PURPOSE OF ASSISTED STRETCHING
The purpose of assisted stretching is to improve flexibility, joint range of motion, and muscular relaxation through guided and supported techniques.

3. POTENTIAL RISKS AND BENEFITS

• Temporary flexibility addictions, or fatigue • Musculoskeletal injury or aggravation of preexisting conditions	• Improved flexibility and range of motion • Enhanced recovery or relaxation • Reduced muscle tension • Improved posture and mobility
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4. HEALTH SCREENING (PARQ-)
Check **YES** or **NO** to each question. Tach question:

Has your doctor ever said you have a heart condition or that you should only do physical activity recommended by a doctor?	YES	NO
Do you feel pain in your chest during physical activity?	☐	☐
In the past month, have you had chest pain when you were not doing physical activity?	☐	☐
Do you lose your balance because of dizziness or do you ever lose consciousness?	☐	☐
Do you have any bone or joint problem that could be made worse by physical activity?	☐	☐
Is your doctor currently prescribing drugs for blood pressure or heart condition?	☐	☐
Do you know of any other reason why you should not participate in physical activity?	☐	☐

Relevant medical conditions, injuries, or surgeries: _____

5. AREAS OF PAIN
Mark areas of discomfort on the figures below.

