CLIENT FORM

The following information will be held completely confidential and is submitted to provide necessary client health information to provide the best use of the Molecular Muscle Integration Therapy.

Name_____

Street_____

City_____State_____Zip_____

Phone _____Age_____ Height _____Weight____ Sex_____

Current Health Information

Major Physical Problem_____

What activities or positions aggravate it? _____

What activities or positions relieve it ? _____

Has there been a medical diagnosis? _____Yes ____ No . If yes, when? _____

What is the diagnosis?_____

Do you have a regular exercise program? _____Yes _____No

Waiver For Health and Wellness Consulting

I understand that Molecular Muscle Integration Therapy, under the direction of Dr. Sharon Johnston, NMD or any consultants there of, are in no way diagnosing nor treating diseases, but is providing information and therapies to restore natural balance and optimum conditions for health and wellness. I agree to indemnify, protect, save and hold harmless Molecular Muscle Integration from any and all liability for any and all complications of any nature should they arise whether to myself or to any minor and /or incompetent for whom I am claiming responsibility.

_____Signature Date _____