FIRST TIME EVALUATION

Today's Date:_____ **Email:** _____

Name:_____ **M ☐ F ☐ Birthdate** ___/___/___ **Age**____

Mailing Address:_____

City:_____**State:** _____ **Zip:** _____ **Occupation:**_____

Height:_____ **Weight:**_____ **Marital Status: S ☐ M ☐ D ☐ W ☐ No. of children:**_____

Daytime phone: (____)_____ **Evening phone:** (____)_____

James Stivaly LMT
225 Walnut Street
Montclair, N.J. 07042
973-746-8007

I_____ understand that the information attained and given to me in this office in no way diagnosis for any disease or a replacement for proper medical care provided by a patients acting Physician. I understand that all information given is for educational purposes only and is not a replacement for Medical advice provided by ones acting Primary Physician.

All of the statements given by James Stivaly LMT and James Stivaly Inc. are for educational purposes only. Any statements or information of any kind given by anyone in this office have not been evaluated by the FDA.

Any formulas suggested are not intended to and do not diagnose, treat, cure or prevent any disease and are suggested for educational purposes only. The consumption of supplements and or remedies of any kind based on information given by James Stivaly or James Stivaly Inc., and the decision to consume said products are the sole responsibility and decision of the client and parent/caregiver of a child receiving information and said products or remedies. I hold harmless James Stivaly LMT/James Stivaly Inc. and any other individual within the confines of this office harmless and will not hold the above said individuals liable in any way for information or techniques given or provided the confines of said office space.

Patient's
Signature_____Date_____

Print Name_____

Caregiver/Parent's Signature_____