

MK Rolfing

Your body is your most valuable asset

Personal Information

Date: _____

Name: _____

Phone: (____) _____ Cell Phone: (____) _____ Fax #: (____) _____

Work Phone (____) _____ E-Mail: _____

Address: _____ Apt.#: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

Occupation: _____

Referred by: _____

Emergency Contact: _____ Phone: (____) _____

Relationship _____ Marital Status: M / S

Have you received Rolfing before? Y / N

Did you injure yourself at work? _____ Y / N, Describe: _____

Medical Physician / Phone: _____

Are you currently taking any medication? _____

What treatments have you received for your condition?

Massage / Physical Therapy / Surgery / Acupuncture / Chiropractic / Medication / Other

List any surgeries _____

Date when your symptoms appeared: _____

How often? _____

Is it constant or does it come and go? _____

What makes it better? _____

What makes it worse? _____

Quality of Pain: please circle

Sharp	Dull	Throbbing	Numbness	Aching	Shooting	Burning
	Tingling	Cramps	Stiffness	Swelling	Other	

Please indicate if you have any of the following:

Low Back Pain	Headaches	Mentally Restless	AIDS / HIV	Pinched Nerve
Sciatic Pain	Difficulty Sleeping	Loose Stools	Muscle Spasms	Spinal fusion
Constipation	Cancer	Muscle Fatigue	Joint Hyper-mobility	Herniated Disk
Shortness of Breath	Dizziness	Arthritis	Digestive Problems	Easily Angered / Agitated
Allergies	Neck pain	General Fatigue	Lack of Appetite	Low Energy

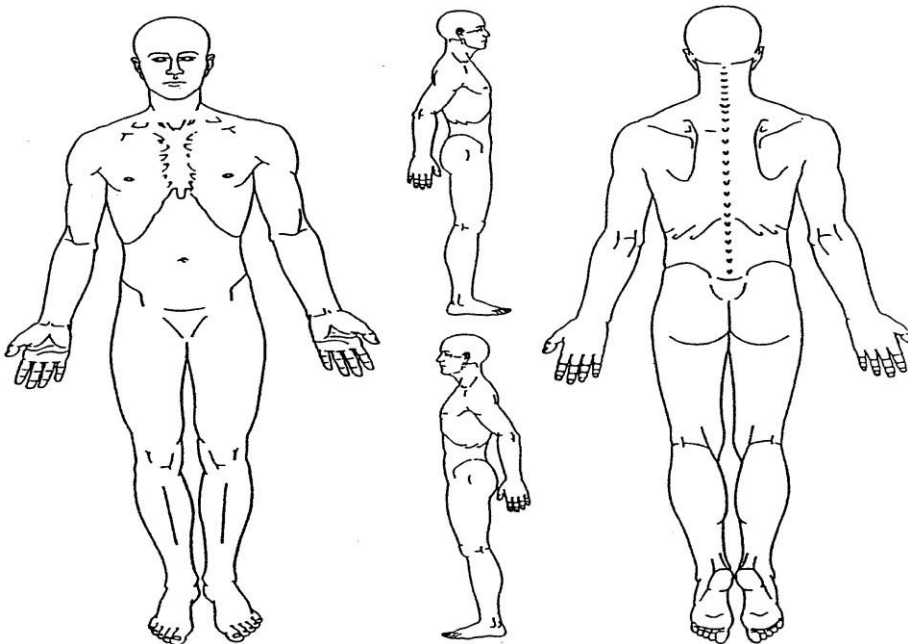
List your major complaints, and rate the severity of each area on a scale from 1(L east Pain) to 10 (Severe Pain):

Area: _____ Pain Level: _____

Area: _____ Pain Level: _____

Area: _____ Pain Level: _____

Please mark your areas of pain:



Please list three things you would like to address in your Roling sessions:

- 1.
- 2.
- 3.

Consent:

I, _____ (please print your name) hereby apply for a series of sessions in Rolfing Structural Integration (SI).

I understand the purpose of Rolfing SI is to balance and restore the physical body so that it is supported and maintained by gravity in three-dimensional space. This is done through direct physical touch and body-centered education; balance and ease in the physical body are main goals of this work.

I further understand Rolfing SI is not involved with treatment of disease of any kind; nor does it substitute for medical diagnosis or treatment when such attention is deemed necessary.

A Certified Rolfer does not treat, prescribe or diagnose illness, disease of any physical or other related ailment of the person seeking Rolfing SI. Nothing said or done by the below named Rolfer should be understood as counter to this statement.

I understand it is necessary for the Rolfer to touch my body in an appropriate manner in order to assist me in establishing balance and ease in my physical body.

I give _____ (**please print Rolfersname**) my permission and consent to work with me in such a way as to restore and establish balance and ease in my physical body. I further understand that I may at any time revoke such permission and consent, and can choose to discontinue the session and series of Rolfing.

In addition, I understand that any relief of physical or emotional symptoms is coincidental in the organization of the total human being and is not a basic goal of Rolfing Structural Integration.

Payment Policy

I, the undersigned, understand and agree to the payment policy. I acknowledge that payment for all care received is my responsibility. Payment is due at time of service unless other arrangements have been made in advance. Payment may be made by cash, check, paypal or credit card. I also understand that a **24-hour cancellation notice** is necessary to avoid charges.

Cancellation Policy

I look forward to helping you. The time you schedule is reserved. **A full session fee will be charged for missed appointments. Cancellations without 24 hours notification will be charged a full session fee .**

I have read, understand, and agree to the cancellation agreement.

Date:

Applicant's Signature: