

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
Bruise Easily	Blood clots	Lymph edema	Thrombosis	Other:

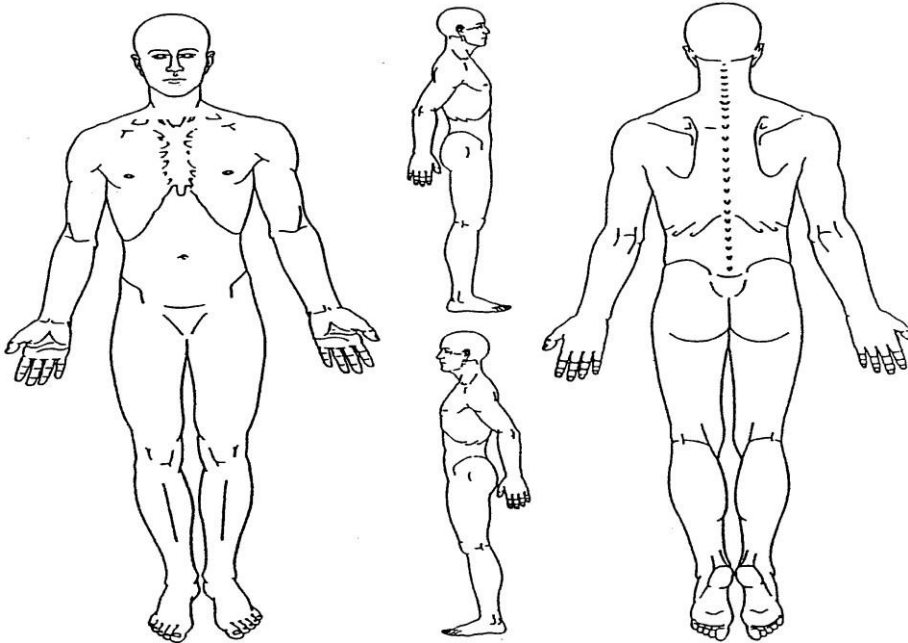
List your major complaints, and rate the severity of each area on a scale from 1(Least Pain) to 10 (Severe Pain):

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.

Waiver Form:

Please take a moment to read and initial the following information:

- I understand that Rolfing SI (massage therapy), provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow. Rolfing SI (massage therapy) is entirely therapeutic
- If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.
- I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.
- I affirm that I have notified my therapist of all known medical conditions and injuries.
- I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.

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 by the Rolfer Marcel Kempf should be understood as counter to this statement.

I further understand that I may at any time revoke such permission and consent, and can choose to discontinue the session

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/ Cancellation Policy

I 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. I also understand that a **24-hour cancellation notice** is necessary to avoid charges. **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 the statement above and agree to all the policies and cancellation policy

Date:

Applicant's Signature: