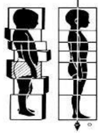

MK Rolfing

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

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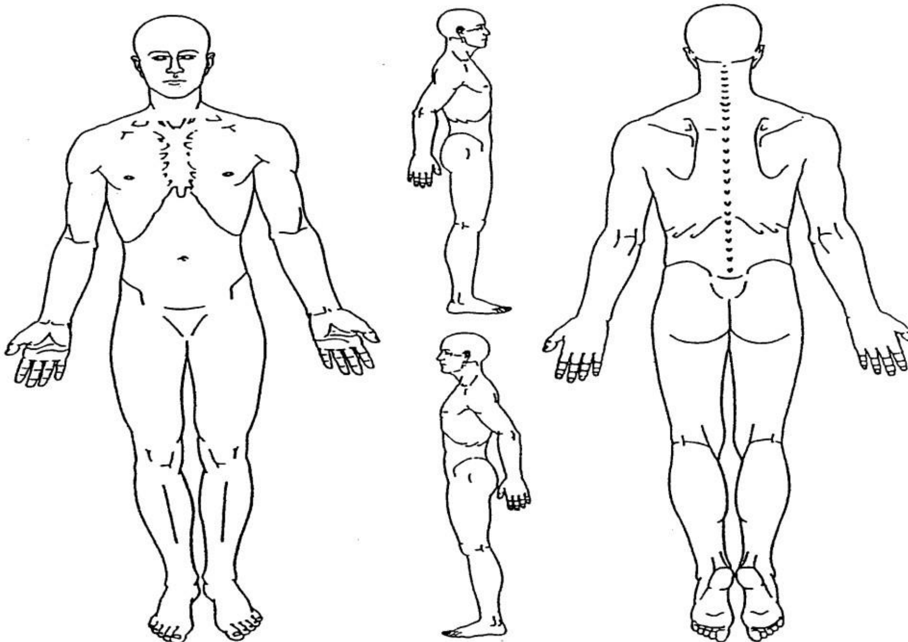
List your major complaints, and rate the severity of each area on a scale from 1(Least Pain) to 10 (Severe Pain):

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 Rolfing 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______________________ (**pleaseprint 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 fee ($ 235.00) will be charged for missed appointments. Cancellations without 24 hours notification will be charged $ 235.00 .**

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

Date: Applicant's Signature: