Intake Form

Name:_____ Date:_____

Phone: H_____C_____W_____
Mailing Address:_____
_____
E-mail: _____

Referred by: _____

Date of Birth: _____ Place Of Birth: _____ Ht._____Wt._____

Occupation_____

Check the Treatments that you have received before: PCP_____

Massage_____Chiropractic_____Acupuncture_____Rolfing/SI_____
Other:_____

Did any treatments help you?_____ If yes, please briefly explain how they helped you and frequency of visits _____
_____
_____

If necessary, do you give permission to contact any of these practitioners? Y/N

What is your main goal for Structural Integration/bodywork?

_____
_____

What is your goal(s) for the series? (Not applicable to all)

_____
_____
_____

General investigation of physical and emotional health:

Please circle all apply:

Arthritis
Asthma/frequent bronchitis or pneumonia
Anxiety
Auto Immune Diseases
Backaches/Neck
Blood Clots.
Cardiac issues/arteriosclerosis/atherosclerosis
Cancer

Diabetes
Depression
Digestive Problems/food intolerance
Eating Disorders.
Epilepsy
Fever
Chemical dependence (medication, alcohol, narcotics)

Fibromyalgia
Gout
Shingles
High or Low Blood Pressure
Headaches/Migranes
Multiple Sclerosis
Pregnant
Sinus Problems/allergies

Psorasis/Eczema
Insomnia/Sleep Apnea
Spasms/Cramps
Stroke
Dizziness/Vertigo
Eye problems
Scoliosis

Current Medications and Supplements:

_____
_____
_____

Allergies: Medications/Latex or other (I.e. food, environmental)

_____
_____
_____

Injuries/Surgeries/Accidents

_____
_____
_____
_____

Movement or exercise practices and frequency

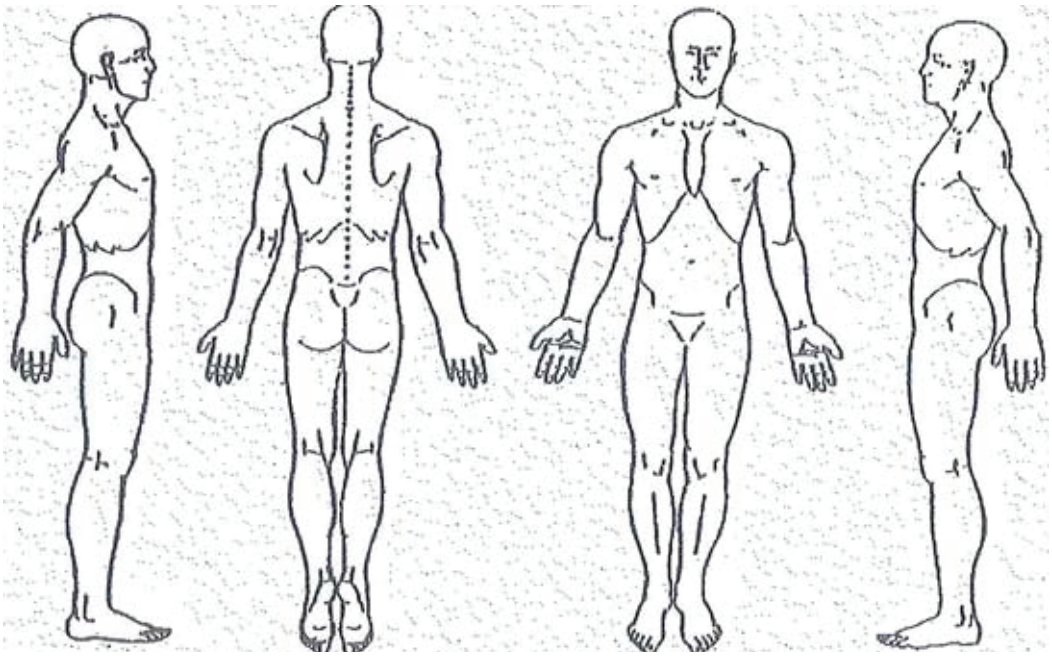
_____
_____
_____

Please indicate any areas below which you are aware of pain or numbness.
Use a **P** for pain and a **N** for numbness.

____neck ____shoulders ___elbows ___hands ___wrists ___hips ___lower back

____ upper back ____knees ____ankles ___feet ___ other (please note below)

Please mark areas of pain on the figures below.



This form is accurate to the best of my knowledge.

Client signature_____

Print name_____

Date _____

Client Consent for the Purposes of Manual Therapy/Bodywork

I_____ give Kat Fiske, Certified Rolfer™ consent for the use and disclosure of my Protected Health Information (PHI) for the specific purpose of providing manual therapy/bodywork to me, receiving payment for services rendered to me for general administrative operations of her practice.

I understand that any manual therapy/bodywork I receive is provided for the basic purpose of relief of muscular tension, stress reduction, better balance, and increased function and movement for overall vitality and wellness.

I further understand that manual therapy/bodywork should not be construed as a substitute for medical examination diagnosis, or treatment.

Manual Therapy/Bodywork is contraindicated under certain medical conditions. I affirm that I have stated all of my known medical conditions, answered all questions honestly, and agree to keep my practitioner, Kat Fiske, updated as to any changes in my medical profile. I understand that there should not be any liability on the part of the practitioner, should I forget to inform her of any such medical conditions.

I have read and understand this notice, and authorization of this form. I also understand that I am not bound to sign this authorization, and that my refusal to sign will not affect my ability to obtain services, nor will it effect my eligibility for benefits. In addition, I understand that I may revoke this authorization at any time by notifying the practitioner in writing.

***** Payment is due at the time services are rendered. Cash, and local checks and pay pal accepted.
***** Returned Check Fee: **$25.00**
***** Please give **24 hour notice** to cancel an appointment or you will be charged for the appointment.
***** If case of illness, please notify the practitioner as soon as possible, so we can reschedule your appointment.
***** If you are late for your session, the session will end at the time it was scheduled till. You will be expected to pay for the length of time you booked your session for.
I read and understand the above policies.

Client Signature _____ Date _____