Body Balance Rolfing and Massage, LLC Confidential Health History

Name Today's Date

Complete Home Address

Home Phone Work/Cell Phone Date of Birth

Marital Status Number of Children Email Address

Pregnant or Nursing Now Miscarriages or Terminations & dates

Glasses Contacts Denture or dental appliances

Occupation and what you **physically** do at work

When was your last massage or Rolfing session? How did you hear about us?

What do you do for pain management?

If you are currently being treated by a doctor for something specific, please explain and give doctor's name and specialty:

Please list ALL **vitamins, mineral, herbs, homeopathics, and medications** you are currently taking and why:

If you have pain: **When** did it start? What **caused** it? **Where** is it? How often do you feel it? On a 1-10 scale (10 being highest), indicate the **location**(s), **intensity**, & **type** of pain (dull, sharp, deep, superficial, shooting, tingling, burning etc.):

List all previous **injuries**, **injections**,and **surgeries** and give approximate dates:

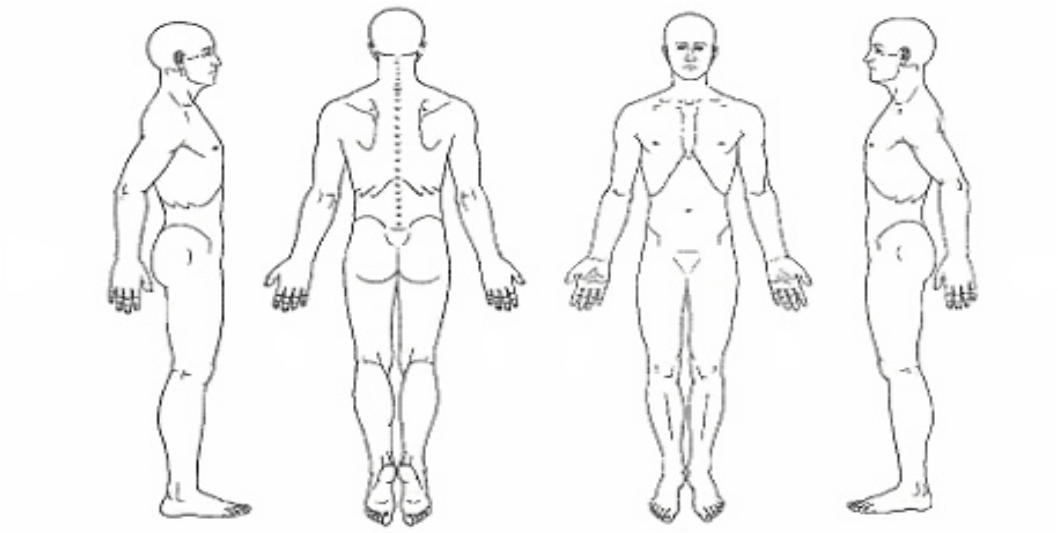
	Quantity	Frequency
Coffee/Tea		
Soda		
Chocolate		
Sugar		
Alcohol		
Tobacco		
Water		

Type of exercise	Frequency

Please **CHECK** all areas of **pain, injury**, or **health condition** that apply:

- Headache
- Neck
- Shoulder
- Upper back
- Mid back
- Low back
- Hip
- Leg/knee
- Ankle/foot
- Arm/hand/wrist/fingers
- Joint pain/ immobility
- Numbness/tingling
- Muscular cramps
- TMJ dysfunction
- Night guard/splint
- Arthritis/bursitis
- Scoliosis
- Fibromyalgia
- Sciatica
- Constipation
- Allergies
- Stress
- Nervousness/anxiety
- Depression
- Sleeping difficulties
- Heart disease
- Diabetes
- Cancer/ tumors
- MS or CP
- Phlebitis/history of blood clots
- Open sore/wound
- Menstrual problems
- Varicose veins
- Skin problems
- Contagious health/skin condition
- Orthotics
- Implants (what type/location)
- Other health condition(s) (please list)

Please **SHADE all areas** of pain patterns, discomfort, and stiffness:



Body Balance Rolfing and Massage, LLC

Client agreements

PRIVACY POLICY:
I acknowledge that I have received Body Balance Rolfing and Massage LLC's Notice of Privacy Policy (also posted on website). I understand that protected health information may be disclosed or used for treatment, payment, or health care operations. I understand that I have the right to request a restriction as to how my protected health information is used or disclosed. Body Balance Rolfing and Massage LLC is not required to agree to this restriction, but if we do so, we shall honor that agreement. Body Balance Rolfing and Massage LLC reserves the right to change the Notice of Privacy Policy.
_____ (initial)

COMMUNICATION:
Body Balance Rolfing and Massage, LLC may leave a message on my home answering machine/voice mail or cell phone as provided on my Health Intake Form.
_____ (initial)

Medical information may be provided to the following person(s):

Name of contact person other than patient	contact information – phone/email

CANCELLATION POLICY:

All cancellations must take place at least 24 hours before the scheduled appointment time in order to avoid the cancellation fee of $65.00. Please be respectful of everyone's time and allow us enough time to book someone else if you cannot make your scheduled appointment. Multiple last minute cancellations will result in future scheduling requests being denied.

Session start and end times are firm. Please arrive on time for your scheduled appointment.

I agree to all of the above regarding privacy, communication, and cancellation policies:

Print Patient Name	Date
Signature of Patient or Personal Representative	Relationship to Patient (if other than patient)

CONSENT TO TREAT:

I fully understand that the purpose of Rolfing is to balance and align the physical body so that it is supported and maintained by gravity in three-dimensional space. This is done through direct manipulation of the soft tissues of the body and includes ongoing education for the purpose of achieving and increase in support and adaptability in the body. However, I understand that Jenny Rock, Certified Rolfer makes no warranties or guarantees regarding the specific results of the Rolfing process in my body.

I understand that neither Rolfing nor massage are involved with the treatment of disease of any kind, nor does it substitute for medical diagnosis or treatment when such attention is needed. Neither the Certified Rolfer™ (Rolfer) nor the licensed massage therapist (LMT) claim to treat, prescribe or diagnose any illness, disease, or any other physical or mental disorder. Nothing said or done by the Rolfer or LMT should be misconstrued to be such.

I hereby consent to and authorize the LMT or Rolfer to conduct such physical examinations and perform such assessments and treatment as the deemed necessary and appropriate. I understand it is necessary for the Rolfer or LMT to physically contact my body in order to treat me. Should treatment be performed, the LMT or Rolfer will fully inform me as to the nature of the procedure, the alternatives to treatment, the risks that are involved, and that I will be given the opportunity to ask questions and have my questions answered.

I **DO/DO NOT** consent to medical photographs to be taken of me (or a person for whom I am legal guardian). I understand that the information may be used in my medical records and refusal to consent will in no way affect the care I will receive.

I **DO/DO NOT** consent to intraoral work when applicable, recognizing that the therapist will be wearing gloves and is properly trained.

I agree to the consent to treat policies described above:

Print Patient Name	Date
Signature of Patient or Personal Representative	Relationship to Patient (if other than patient)