Barbara Jean Conti
Rolfing® Structural Integration

201 E Hennepin Ave, Suite 204
Minneapolis, MN
612-817-5571

Client Information

Date:_____

Name: _____
Preferred Pronoun(s): _____
Phone: _____
Email: _____
Street Address: _____
City, State, Zip _____
Occupation: _____

Alternative contact person & phone no.: _____
Activities / hobbies: _____
How did you hear about Barbara? _____

Health Information

What brought you in today? _____
Level of pain today (1=low to 10=maximum) _____

Please indicate if you have or have had any of these health conditions and explain.

Condition	When	Explain and list medications
Skin Conditions	NA Now Past	
Cardiovascular conditions (ex: blood clots, varicose veins, heart condition, high blood pressure, stroke)	NA Now Past	
Arthritis, scoliosis, joint or bone problems or breaks	NA Now Past	
Surgery, falls, accidents	NA Now Past	
Pain, numbness, tingling	NA Now Past	
Swelling, sensitive to touch, bruise easily	NA Now Past	
Diabetes	NA Now Past	
Headaches, migraines, neurological conditions	NA Now Past	
Respiratory (lung) conditions	NA Now Past	
Allergies, sensitivities	NA Now Past	
Digestive, liver, kidney conditions	NA Now Past	

Any medical condition or concern not otherwise listed? _____

Are you now under a doctor's, chiropractor's, or other health practitioner's care for any other acute or chronic condition not identified above? Yes No If yes, for what? _____

If female, are you pregnant? Yes No If yes, due date: _____

Continued on other side

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Acknowledgment of Receipt of Complementary and Alternative Care Client Bill of Rights

I have received a copy of the Complementary and Alternative Care Client Bill of Rights. I have read and understand it, or it has been read to me. I have had a full opportunity to ask any questions I have about this document and my rights as a client.

Signature: _____Date:_____

Consent to Receive Manual Therapy (Bodywork) and Waiver of Liability

If I experience pain or discomfort during the session, I will immediately inform my practitioner so that pressure / strokes can be adjusted to my level of comfort. I will not hold my practitioner 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 practitioner is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

I affirm that I have notified my practitioner of all known medical conditions and injuries.

I agree to inform the practitioner of any changes in my health and medical condition. I understand that there shall be no liability on the practitioner's part should I forget to do so.

I understand that manual therapy (Rolfing® Structural Integration, ScarWork and CranioSacral Therapy) is entirely therapeutic and non-sexual in nature.

By signing this release, I hereby waive and release my practitioner from any and all liability, past, present, and future relating to Rolfing® Structural Integration, ScarWork and CranioSacral Therapy.

Signature: _____Date:_____

Consent and Release of Parent or Guardian

I am the parent or guardian of _____ and I consent to my child's participation in Rolfing® Structural Integration manual therapy, ScarWork or CranioSacral Therapy. I have read and understand the above waiver.

Signature: _____Date:_____