

Sharalee Hoelscher, RCST®, Certified Rolfer™ (Lic.#MA34039)
CLIENT INTAKE FORM

Name _____ Date of Birth _____
Address _____
City _____ State _____ Zip _____
Phone (Home) _____ (Cell) _____ (Work) _____
Emergency Contact _____ Phone _____
Referred by _____

Past or Current: I have had the following: Injuries Accidents Surgeries Birth Trauma
Comments: _____

Current medications: _____

List any types of health care or medical treatment you are currently receiving:

Circle any of the following that apply to your current or past health:

Pregnancy	Heart Condition	Cancer	High Blood Pressure
Blood Clots	Breathing Problems	Arthritis	Skin Conditions
HIV/AIDS	Balance Problems	Infections	Major Illness
Injuries	Accidents	Surgeries	Birth Trauma

Comments: _____

What do you know about your own birth? _____

Occupation _____ Stress Level _____

What gets you through difficult times? _____

Exercise type and frequency _____

Have you received Rolwing® or Structural Integration before? ____ # of sessions _____

Have you received Craniosacral Therapy before? _____ Frequency _____

Reason for today's visit: _____

CONSENT FOR CARE

It is my choice to receive Rolwing® structural integration and/or Craniosacral therapy. I am aware of the benefits and risks of Rolwing SI and/or Craniosacral therapy and give my consent for Rolwing SI and/or Craniosacral therapy. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I understand that Rolwing SI or Craniosacral therapy is not involved with the treatment of disease, illness, or disorders of any kind, nor is it a substitute for medical diagnosis or treatment when such attention is needed. Likewise, Rolwing practitioners or Craniosacral therapists do not diagnose or treat any illness, disease or other physical or mental disorder of the person. I understand that any relief of physical or emotional symptoms is coincidental to the Rolwing SI or Craniosacral therapy process and is not a goal of Rolwing SI or Craniosacral therapy. I understand that medical insurance may not pay for Rolwing SI and/or Craniosacral therapy and agree to be responsible for the cost of my appointment at the time of treatment.

Signed _____

Date _____