Sharalee Hoelscher 4300 Bayou Blvd., #22, Pensacola, FL 850-450-8508 (MM19060)

DO NOT TEXT OR EMAIL THIS FORM. BRING IT TO YOUR APPOINTMENT.

Full Legal Name_____ Age _____

Home Address_____

City_____State_____Zip_____

Phone _____Emergency Contact & Phone_____

Your Occupation_____Referred by _____

List below ALL Injuries, anywhere in the body, from birth to present

_____

List below ALL Accidents, even if unrelated to current problem, from birth to present

_____

List below ALL Surgeries; include cesarean, cosmetic surgeries, from birth to present

_____

I use: Brace/Splint Orthotics/Shoe Inserts Night Guard for teeth Foam Roller

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

_____

Treatments I have tried for current condition_____

I use medications for the following:_____

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

Breast Implants	Mesh from surgery	Pins/screws/plates	Birth Defect
Blood Clots	Breathing Problems	Arthritis	Skin Conditions
HIV/AIDS	Balance Problems	Infections	Diabetes
Pregnancy	Heart Condition	Cancer	High Blood Pressure

Comments:_____

Exercise type and frequency_____

Daily stretches, physical therapy, other routine_____

Have you received Rolfing® or Structural Integration before?____ # of sessions_____

Have you received Craniosacral Therapy before?_____ Frequency_____

Describe in detail the condition you wish to be treated:

_____

MISSED APPOINTMENTS

I agree to pay in full for any appointment missed if I do not provide 24 hours notice.

Signed_____ Date_____

CONSENT FOR CARE

I understand that insurance may not pay for Rolfing and/or Craniosacral Therapy (CST) and agree to be responsible for the cost of my appointment at the time of treatment. I understand the cost of my appointment does not include providing any information to any other party including insurance providers, attorneys, and health care providers, and agree to pay for providing any such information as necessary. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. The following has been explained to me verbally ____ or in writing ____: the benefits, risks, contraindications, and nature of Rolfing and/or CST; Rolfing or CST does not diagnose or treat disease, illness, or disorders of any kind, nor is it a substitute for medical diagnosis or treatment when such attention is needed; there is no guarantee of success or effectiveness of Rolfing or CST; the education, experience, and credentials of Sharalee Hoelscher Hurtubise (MA34039) in regard to Rolfing and CST and my treatment. I give my consent for Rolfing and/or CST.

Signed_____ Date_____