Boston Body Balance

Client Intake

Name: _____ Date of Birth: _____ Height: _____

Mailing Address: _____ City, Zip: _____

Preferred Phone #: _____ Email: _____

Occupation: _____ Stress Level: _____

What gets you through difficult times? _____

Exercise type and frequency: _____

How did you hear about Boston Body Balance? _____

Have you received Rolfing® or Structural Integration before? _____ # of sessions: _____

What do you hope to get out of Rolfing SI? _____

_____

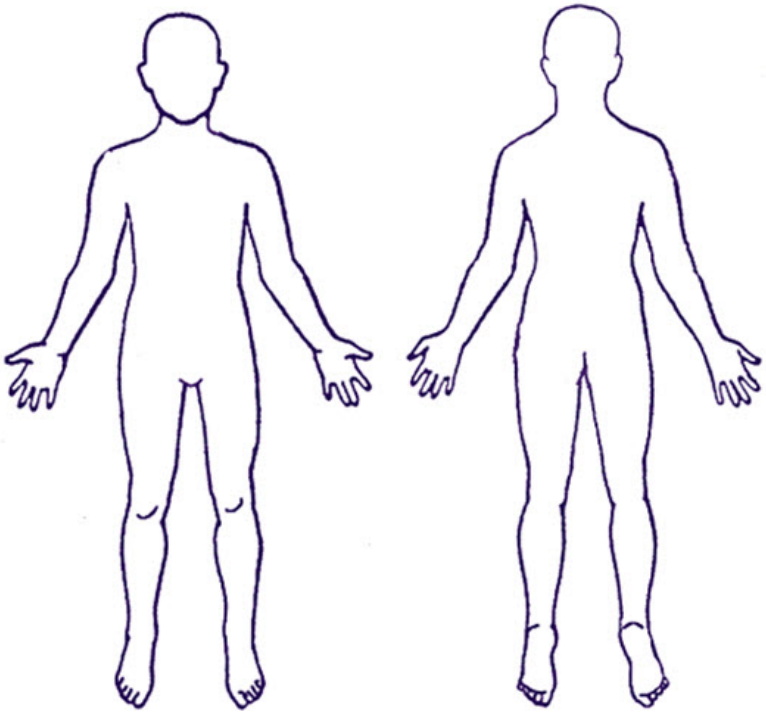
Consent for Care

I, _____, choose to receive Rolfing® Structural Integration (SI), knowing that I can stop at any time for any reason. **I will let my Rolfer™ know immediately if I experience any pain, tingling, numbness, or discomfort at any point during a Rolfing session.** I understand that there are no guaranteed outcomes, and that Rolfing SI is not a medical treatment of disease or disorder of any kind, nor is it a substitute when such attention is needed. I understand that Rolfers are not qualified to diagnose any medical condition or give medical advice. I have stated all medical conditions that I am aware of and will inform my Rolfer of any changes in my health status. No medical professional has recommended that I avoid receiving massage or other manual therapies.

I will pay the full cost of my appointment at the time of treatment, unless other written arrangements have been made. **I will pay the full price of an appointment for any missed sessions (no-shows) or a $50 fee for appointments that are cancelled with less than 24 hours notice.**

Signed: _____ Date: _____

Chronic and Current Pain



Location(s): _____

_____

Frequency & Duration: _____

_____

When did this start? _____

Intensity & Description: (sharp, aching, radiating, burning, stiffness, pulling, etc.)

_____

_____

What helps? _____

_____

What makes it worse? _____

_____

What else have you tried? _____

Are you currently receiving any types of medical treatment or bodywork? Yes / No

Type of care: Physical Therapy, Chiropractic, Massage, Acupuncture, Other _____

Other Concerns: _____

Please rank yourself (0-10) in the following areas of self-care for the last month

0 = I've done nothing to meet this need and I've sabotaged opportunities that present themselves to me.
5 = I feel like I could do better, but it isn't bothering me.
9 = I am satisfied with this area of my life and I trust I will continue to meet this need.
10 = I am excellent at including this in my regular life.

Nutrition: _____ Exercise: _____ Sleep and Rest: _____

Support Received: _____ Support Given: _____ Assertiveness: _____

Centering and Solitude: _____ Creativity and Artistic Expression: _____

Personal Goal Met: _____ Fun: _____ Total: _____

Self-Care Goal for this coming week: _____

Circle any of the following that have <u>ever applied</u> to you:

Year (s)	Experience	Present Consequences
	Heart Condition - Blood Clots - Problems Clotting	
	Major Illness - Chronic Illness	
	Pregnancy - Vaginal Birth - C-Section - PMS	
	Arthritis - Spondylolisthesis - Scoliosis	
	Repeated Injury - Tendonitis - Bursitis	
	Plantar Fasciitis - Shin Splints - Compartment Syndrome	
	Orthotics - Very Supportive or Minimalistic Shoes	
	Car Accident - Bike Accident - Whiplash - Concussion	
	Major Injury - Broken Bone - Joint Injury	
	Surgery - Cortisone Injections - Prolotherapy	
	Nerve Damage - Carpal Tunnel Syndrome - Sciatica	
	Tension Headaches - Migraines - Vision Problems	
	TMJ Problem - Jaw Pain - Teeth Grinding &/or Clenching	
	Braces - Headgear - Retainer - Night Guard	
	Balance Problems - Vertigo - Ménière's Disease	
	Trauma - PTSD - Overwhelming Stress - Sleep Difficulties	
	Breathing Problems - Asthma - Allergies - Sleep Apnea	
	Skin Conditions - Sensory Integration Difficulties	
	Other:	