CARING HANDS Integrated Wellness, LLC ***Patti A Selleck, Certified Advanced Rolfer®.***

CLIENT INFORMATION

PLEASE PRINT CLEARLY

Name _____

Address _____ Apt. No. _____

City _____ State Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Occupation _____

E-mail address _____

Birth Date _____ Referred By _____

Primary reason for appointment/health goals: _____

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YES NO Is there any medical condition that we should be aware of before giving your treatment? If so, describe:

_____

YES NO Have you ever had a professional massage or Structural Integration?

Please place a check by any of the conditions you may have experienced. Do or have you:

_____ Use vitamins and nutritional supplementation regularly_____

_____ had surgery _____ __ skin sensitivity _____ ____take prescription medications(over)_____

_____ suffered an acute injury due to a fall or accident Describe:_____

_____ broken bones _____

_____ low back pain _____ shoulder pain _____ Spinal problems _____

_____ head, neck, or whiplash injury When:_____ _____ broken nose

_____ foot or ankle injury Describe:_____ _____ knee injury Describe:_____ have varicose veins

_____ exercise regularly or play sports _____

_____ any heart problems _____ high or low blood pressure _____

_____ sciatic nerve_____

_____ are you pregnant Pregnancy difficulties_____Diabetes_____

_____ kidney or bladder problems _____

_____ prostate problems _____

_____ tense or sore areas _____

_____ arthritis Describe:_____

_____ headaches How often: _____

_____ problems with TMJ _____ _____

_____ tingling in the arms or legs _____

_____ digestive problems _____ chronic or alternating diarrhea or constipation_____

_____ asthma, sinus surgery _____

_____ flat feet _____

_____ carpel tunnel syndrome _____

_____ fibromyalgia _____

_____ anxiety _____ fatigue _____ depression_____

_____ any other medical condition to be aware of _____

Please use space provided to explain any conditions from above. _____

_____

What if anything do you do to relax? _____

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I have stated all my known medical conditions and take it upon myself to update you regarding my physical health.
As a courtesy to my therapist I understand that a 24-hour notice of cancellation is a must or I will be charged for the visit.

Signature_____ Date _____