

Welcome. Please complete both pages before your first session so the work can be tailored to your body. Everything you share is kept confidential.

1 About you

Full legal name

Date of birth

Phone

Email

Home address

Emergency contact & relationship

Emergency phone

Primary care physician & phone

Occupation

How did you hear about us?

Best way to reach you: ☐ Phone ☐ Text ☐ Email

2 Your goals

What brings you to Rolfing Structural Integration?

What would you like to feel or do differently after our work together?

How long have you had these concerns?

What makes them better or worse?

I'm interested in: ☐ The classic 10-session series ☐ A few targeted sessions ☐ Not sure yet

3 Health history

Check anything that applies now or in the past. Items in **bold** mean we will need to reschedule your session.

- | | | |
|--|---|--|
| ☐ High or low blood pressure | ☐ Heart condition / pacemaker | ☐ Blood clot or DVT (current) |
| ☐ Taking blood thinners | ☐ Diabetes | ☐ Osteoporosis / osteopenia |
| ☐ Arthritis | ☐ Herniated or bulging disc | ☐ Scoliosis |
| ☐ Joint replacement, pins, implants | ☐ Fibromyalgia / chronic pain | ☐ Autoimmune condition |
| ☐ Cancer (current or past) | ☐ Epilepsy or seizures | ☐ Migraines or headaches |
| ☐ Numbness, tingling, nerve pain | ☐ Skin condition, bruising, varicose veins | ☐ Contagious illness, fever, infection |
| ☐ Anxiety, depression, or trauma | ☐ Pregnant (weeks ____) / postpartum | ☐ Allergies (oils, lotions, latex) |

Details on anything checked

Surgeries (type and year)

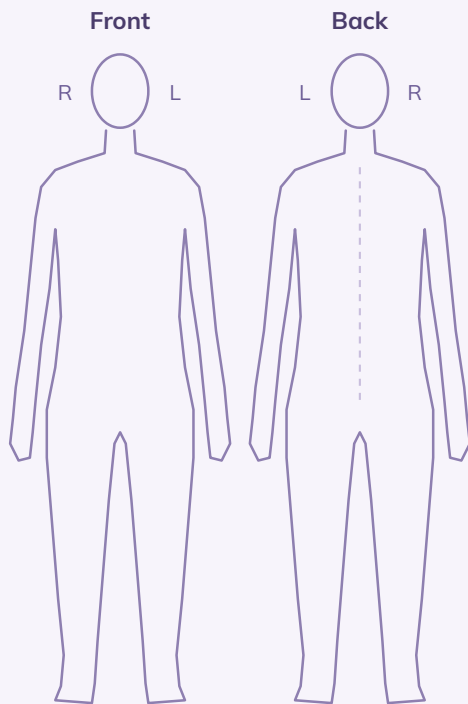
Injuries, accidents, falls, or fractures (type and year)

Current medications and supplements

Currently seeing a doctor, chiropractor, or physical therapist? For what?

4 Where you feel it

Circle every area that bothers you, then mark it with a symbol from the key.



X Pain / Tightness **O** Numbness / tingling
Write 0–10 beside each mark (10 = worst)

TOP CONCERNS, IN ORDER

#	Area	Pain 0–10	How long?
1			
2			
3			

DAILY LIFE

Exercise or movement practice (type, how often) _____

Hours a day sitting or driving _____

Sleep position and quality _____

Stress level 0 1 2 3 4 5 6 7 8 9 10

BODYWORK PREFERENCES

Rolfing or Structural Integration before? When, with whom? _____

Other bodywork (massage, chiropractic, PT, etc.) _____

Areas you do NOT want worked on _____

Pressure: ☐ Light ☐ Moderate ☐ Firm ☐ Not sure

Comfortable in: ☐ Underwear ☐ Shorts / sports bra

☐ Let's discuss

5 Consent & policies

I understand Rolfing® Structural Integration is hands-on, movement-based work with fascia and connective tissue. Sensations can be intense, and I may ask to adjust or stop at any time.

Initials _____

This work is not a substitute for medical care. My practitioner does not diagnose, prescribe, or treat medical conditions.

Initials _____

I have shared all known health conditions and medications and will report any changes.

Initials _____

Before-and-after posture photos may be taken to track progress. They stay confidential and are never shared without my written permission. (Cross out to decline.)

Initials _____

Cancellations need at least 24 hours' notice. Late cancellations and no-shows may be charged the full session fee.

Initials _____

Sexual or inappropriate behavior or remarks end the session immediately, with full payment due.

Initials _____

I have read and understand this form and consent to receive Rolfing® Structural Integration from Paige Dayvis, Certified Rolfer™ and LMT MA110456, at Center of Integration.

Client signature _____

Date _____

Printed name _____

Parent / guardian (if under 18) _____

Practitioner · Certified Rolfer™ · LMT MA110456 _____

Date _____