



elementalbodywork

structural bodywork & educational resources

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City/ State/ Zip: \_\_\_\_\_

Phone Number: (H/ W/ C) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email Address: \_\_\_\_\_

Referred By: \_\_\_\_\_ Occupation: \_\_\_\_\_

Have you received, or do you regularly receive, some form of massage/bodywork? \_\_\_\_\_

If yes, how often do you receive work? When was your last session? What were the results? \_\_\_\_\_

\_\_\_\_\_

Are you familiar with and/or have you received Structural Integration? (KMI, Rolfing, Hellerwork, Soma). If, yes, what has been your experience? \_\_\_\_\_

\_\_\_\_\_

Are you currently under the care of another practitioner? (Physician/chiropractor/ PT/ acupuncturist/ mental health therapist? If so, please state the reason, duration and provider's name. \_\_\_\_\_

\_\_\_\_\_

Are you currently taking medication or supplements prescribed by a physician? If so, please list below. \_\_\_\_\_

\_\_\_\_\_

Are you taking any over the counter medications? If so, for what condition / symptoms? \_\_\_\_\_

\_\_\_\_\_

Have you had any recent accidents, injuries or illnesses? If within the last year, please provide a brief description and the approximate date/s. \_\_\_\_\_

\_\_\_\_\_

Please note any past (over one year) injuries or illnesses and approximate dates as well as treatment received. \_\_\_\_\_

\_\_\_\_\_



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Please check any of the conditions below that apply to you, including past conditions.

- |   |  |
|---|--|
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Menstrual Problems  |
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Multiple Sclerosis  |
| <input type="checkbox"/> Cancer   | <input type="checkbox"/> Mental/ Nervous Disorder (e.g. OCD, Depression)                 |
| <input type="checkbox"/> Contagious Condition (e.g. athlete's foot, pink eye) | <input type="checkbox"/> Numbness/ Tingling  |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Open Cuts / Sores   |
| <input type="checkbox"/> Digestive Disorder                                   | <input type="checkbox"/> Osteoporosis/ Osteopenia  |
| <input type="checkbox"/> Dizziness  | <input type="checkbox"/> Pregnant  |
| <input type="checkbox"/> Easy Bruising  | <input type="checkbox"/> Skeletal Disorder (joint dislocation, bone breaks or fractures) |
| <input type="checkbox"/> Epilepsy or Seizures                                 | <input type="checkbox"/> Skin Disorder (e.g. psoriasis, eczema)                          |
| <input type="checkbox"/> Fatigue  | <input type="checkbox"/> Stroke  |
| <input type="checkbox"/> Headaches  | <input type="checkbox"/> Swelling  |
| <input type="checkbox"/> Heart Condition                                      | <input type="checkbox"/> Varicose Veins  |
| <input type="checkbox"/> High/ Low Blood Pressure                             |  |
| <input type="checkbox"/> HIV/ AIDS  |  |

The lists above are not all inclusive. Please list any other health conditions that you may have:

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How do you use your body on a daily basis? What forms of exercise/ wellness/ self-care do you practice?

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How would you describe your diet? \_\_\_\_\_

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How would you describe/ rate your sleep quality? \_\_\_\_\_

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Do you have any areas of chronic body discomfort? What activities or events make it better? Aggravate it?

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Where or when do you feel most at ease in your body? \_\_\_\_\_

\_\_\_\_\_

What are your goals for today's bodywork session? Please list any specific conditions or areas that you would like addressed today. \_\_\_\_\_

\_\_\_\_\_

Is there anything else that you would like to discuss regarding your goals, bodywork in general or series work? Is there anything else you would like me to know? \_\_\_\_\_

\_\_\_\_\_

#### Informed Consent for Bodywork

I, \_\_\_\_\_ understand that I will be receiving structural integration or therapeutic bodywork (manual therapy). I understand that the purpose of structural integration is to balance and align the physical body so that it is supported and maintained by gravity in three-dimensional space. I understand the purpose of therapeutic bodywork is to establish and maintain good health and physical condition. I understand that structural integration or therapeutic bodywork is not intended to treat medical conditions and should not take the place of a doctor's care. I understand that Amy Bennett LMT, BCSI<sup>cm</sup> does not diagnose, prescribe or treat any physical or mental illnesses and that anything said in the course of a session should not be construed as such. Because bodywork/ manual therapy should not be performed under certain circumstances, I affirm that I have stated all of my medical conditions and answered all questions honestly. I agree to keep my therapist updated if there are changes in any medical conditions or my health status.

I understand that either the therapist or the client may request a change in treatment or behavior should either be experiencing discomfort inappropriate to the situation. I understand that payment is required at the end of the session unless previous arrangements have been made.

#### Cancellation Policy

I understand and agree to a minimum of 24 hours notice for cancelled appointments. I understand that if I miss an appointment with less than 24-hour notice, I will be charged the full amount\*.

\*Exceptions considered for illness and/ or emergencies

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_