Sterling Cassel, Certified Rolfer
CLIENT INFORMATION FORM

Name: ____ Today's Date: ___________________________

Address: __________________________________ Height: _________ Weight_______________
City: ______________________________ State: _______ Zip:____________ Date of Birth: ______________

Phone H:______________ W:_______________ Cell: ________________ E-mail: _______________________

Occupation: __________________________________ Employer: _____________________________________

Emergency Contact Name & Number (include cell): ____

Activities such as hobbies, sports, etc.: ____
____

Marital Status: ___________ Number of Children: _____ Ages: ____

Are you now under the care of a physician or other health care practitioner? ____ If so, for what conditions?
____

Please list any medications you are currently taking: ____

Check all that apply:

___ Contact Lenses
___ Osteoporosis
___ Orthodontic Devices
___ Infections or Contagious Conditions
___ Open Cuts or Sores
___ Varicose Veins
___ Digestive Problems
___ Circulatory Problems
___ Breathing Problems
___ Sinus Pain
___ Headaches
___ Ear Ringing/Tinnitus
___ Blurred Vision
___ Dizziness
___ Numbness or Tingling
Please describe: _____________
____

___ Arthritis (which type?_______________
___ Orthopedic Devices
___ TMJ Problems
___ Repetitive Stress or Motion Problems
Please describe:______________________________________
___ Carpal Tunnel Syndrome
___ Tendonitis
___ Bursitis
___ Fibromyalgia
___ Fatigue
___ Sleeping Problems
___ Neuralgia/Neuritis
___ Fasciitis (incld. Plantar Fasciitis)
___ Scoliosis
___ Any Skin Conditions:
Please describe: ________________________________
___ Thoracic Outlet Syndrome

___ Mental Illness
Please describe: ____
___ Chronic and/or Acute Pain
If so, please describe: ____
____
____
____

*****ON BACK*****

Any surgeries? ______When?____
Please describe: ____
____

Accidents, injuries, or illnesses? ________ When?:____
Please describe: ____
____
____
____

Are there any other conditions or history your practitioner should be aware of? ____________________
Please describe:____
____

Please list any previous bodywork experience: (i.e. massage, chiropractor, acupuncture, etc.) ____________
____

Please list current bodywork or other therapies you are currently receiving:____________________
____

Have you been Rolfed?____Name of Rolfer: ____________________ How many sessions? ____________
When was your last session? ____

How did you learn about me? ____

What are your goals/desired outcome of our work together?:____________________
____
____

Consent:
I understand the purpose of Rolfing is to balance and align the physical body. This is done through direct and indirect manipulation of tissues, movement, and education. I understand that there are no guarantees regarding the results of the process.

I understand that this process does not diagnose any disease, illness or ailment (physical or mental) and is not a substitute for the medical treatment of such.

____ ____________________
Signature Date

Cancellation Policy:

24 Hours Notice is required for Cancellation of Appointment or service fee may be charged.

____ Please check if you would like to receive periodic emails. Please note that you may unsubscribe at any time.