Body Literacy Project

Client Intake Form

Client Name: _____ Pronouns: _____

Date of Birth: _____ Height: _____

Caregiver Name (if client is a minor): _____ Pronouns: _____

Phone #: _____ Email: _____

Consent for Care

I, _____, choose to receive Body Literacy Instruction and/or Rolfing® Structural Integration (SI), knowing that I can stop at any time for any reason. ***I will tell Jazmine immediately if I experience any pain, tingling, numbness, or discomfort at any point during my 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 Jazmine 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: _____

Occupation: _____ Stress Level: _____

What gets you through difficult times? _____

Hobbies: _____

Exercise type and frequency: _____

How did you hear about Jazmine the Rolfer™? _____

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

Practitioner name:_____ When: _____

What would you like to get out of this work? _____

_____

What do you like about your body and/or your relationship with your body? _____

_____

What would you like to change about your relationship with your body? _____

_____

Please rank yourself in the following practices of self-care for the last month

0 = I've sabotaged opportunities that present themselves to me.
1 = I've done nothing to meet this need.
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 / Solitude:	_____	Creativity / Artistic Expression:			_____
Personal Goal Met:	_____	Fun / :	_____		

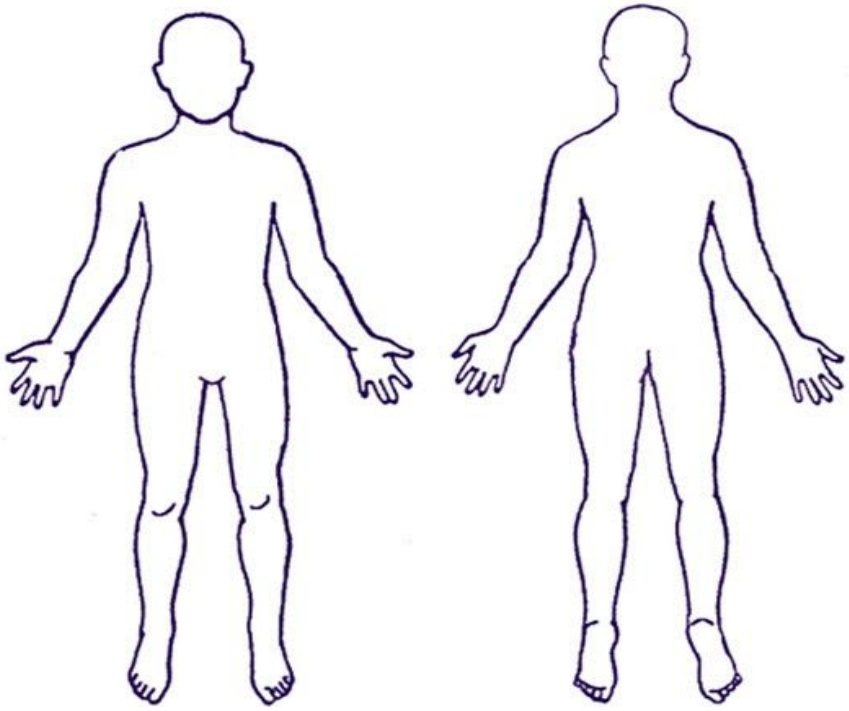
Total: _____

Self-Care Goal for this coming week: _____

History- Please circle any of the following that have ever applied to you:

Experience	Years of Impact
Arthritis - Spondylolisthesis - Scoliosis	
Osteoporosis - Osteopenia	
Heart Condition - Blood Clots - Problems Clotting	
Major Illness - Chronic Illness - Digestive Difficulties	
Pregnancy - Vaginal Birth - C-Section - Menstrual Pain	
Incontinence - Pelvic Floor Dysfunction / Difficulties	
Tension Headaches - Migraines - Vision Problems	
TMJ Problem - Jaw Pain - Teeth Grinding / Clenching	
Braces - Headgear - Retainer - Night Guard	
Balance Problems - Vertigo	
Trauma - PTSD - Overwhelming Stress	
Sleep Difficulties - Sleep Apnea	
Breathing Problems - Asthma - Allergies	
Skin Conditions - Sensory Integration Difficulties	
Car Accident - Bike Accident - Whiplash - Concussion	
Major Injury - Broken Bone - Joint Injury	
Surgery - Cortisone Injections - Prolotherapy	
Nerve Damage - Carpal Tunnel Syndrome - Sciatica	
Repeated Injury - Tendonitis - Bursitis	
Plantar Fasciitis - Shin Splints - Compartment Syndrome	
Orthotics - Very Supportive or Minimalistic Shoes	
Other:	

Describe Troubling Sensations



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 medical treatment or bodywork? Yes / No

Type of care: Physical Therapy / Chiropractic / Massage / Acupuncture / _____

Have you ever had a negative reaction to bodywork or other treatment? _____

Other Concerns: _____