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DO NOT TEXT OR EMAIL THIS FORM. BRING IT TO YOUR APPOINTMENT.

Name _____ Age _____

Address _____

City _____ State _____ Zip _____

Phone (Home) _____ (Cell) _____ (Work) _____

Emergency Contact _____ Phone _____

Your Occupation _____ Referred by _____

List below ALL Injuries, anywhere in the body, from birth to present

List below ALL Accidents, even if unrelated to current problem, from birth to present

List below ALL Surgeries; include cesarean, cosmetic surgeries, from birth to present

What do you know about your own birth? _____

I use: Brace/Splint Orthotics/Shoe Inserts Night Guard for teeth Foam Roller

List any types of health care or medical treatment you are currently receiving:

I use medications for the following: _____

Circle any of the following that apply to your current or past health:

Breast Implants Mesh from surgery Pins/screws/plates Birth Defect

Blood Clots Breathing Problems Arthritis Skin Conditions

HIV/AIDS Balance Problems Infections Diabetes

Pregnancy Heart Condition Cancer High Blood Pressure

Comments: _____

Exercise type and frequency _____

Any former sports or exercise _____

Daily stretches, physical therapy, other routine _____

Have you received Rolwing® or Structural Integration before? _____ # of sessions _____

Have you received Craniosacral Therapy before? _____ Frequency _____

What is your goal for Rolwing or Craniosacral? _____

MISSED APPOINTMENTS

I agree to pay in full for any appointment missed if I do not provide 24 hours notice.

Signed _____ Date _____

CONSENT FOR CARE

I am aware of the benefits and risks of Rolwing and/or Craniosacral Therapy (CST) and give my consent for Rolwing and/or CST. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand there is no guarantee of success or effectiveness of Rolwing or CST. I understand that Rolwing or CST does not diagnose or treat disease, illness, or disorders of any kind, nor is it a substitute for medical diagnosis or treatment when such attention is needed. I understand that insurance may not pay for Rolwing and/or CST and agree to be responsible for the cost of my appointment at the time of treatment. I understand the cost of my appointment does not include providing any information to any other party including insurance providers, attorneys, and health care providers, and agree to pay for providing any such information as necessary.

Signed _____ Date _____