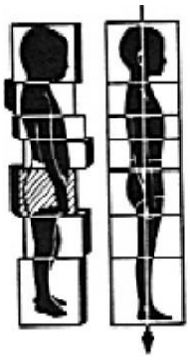
ROLFING INSIGHT



Thom Shenk Advanced Rolfer and Rolf Movement Therapist

Licensed MST, Visceral & Neurofascial Manipulation, CSR

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Address: 5410 Edson Lane. Sweet #350 Rockville, MD. 20852

Today's Date: _____/_____/_____
Name: _____
D.O. B: _____/_____/_____Age: _____Gender: _____Height: _____Weight: _____
Home Address: _____
City: _____State: _____Zip: _____
Cell Phone #: _____ E-mail: _____
Home Phone #: _____ Business Phone: _____
The best way to contact me is: _____
Occupation/Employer_____
Type of Work_____
Emergency Contact and relationship: _____
Emergency contact Phone number and pertinent information: _____
_____
Referred to this office by: _____

* Please read and sign the following pages: *

Purpose for this appointment:_____
Major Complaints:_____
Doctors seen for this Condition: _____
When did you last have therapy and for what? _____
_____
Are there others in your family with this condition:_____
Do you have any particular goals in mind for this bodywork session: _____
List types of therapy received in the past: _____

_____
Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes ( ) No ( )
If yes, please explain: _____ _____
Do you have any difficulty lying on your front, back or side? Yes ( ) No ( )

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Do you have sensitive skin? Yes ( ) No ( )

Any known allergies and or sensitivities to topical applications? Yes ( ) No ( )
If yes, please explain: _____

Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes ( ) No ( ) If yes, please identify: _____
Are you wearing any of the following? Contact lenses ( ) dentures ( ) a hearing aid ( )
Do you sit for long hours at a workstation, computer or driving? Yes ( ) No ( )
Do you perform any repetitive movement in your work, sports or Hobby? Yes ( ) No ( )
If yes, please explain: _____

Medical History

Do you have or have you had any of the following conditions? Check appropriate lines.

___ High/Low Blood Pressure	___ Neck/Spine injuries	___ Recent Surgery
___Sciatica	___ TMJ Syndrome	___ Fractures
___ Heart Condition	___ Serious Accident	___ Flu/Cold/Fever
___ Emotional change	___ Varicose Veins	___ Arthritis
___ Eating Disorders	___ Any Contagious Disease	___ Inflammation
___ Diabetes	___ Internal Organ Dysfunction	___ Insomnia
___ Epilepsy	___Breathing Problems	___ Headaches
___ Cancer	___ Skin Disorders	___ Pregnancy
___ Decreased ROM	___ Allergies	___ Hypoglycemia
___ Slipped/Ruptured Disc	___ osteoporosis	___Chronic/Acute Pain
___Numbness/weakness/coldness	___Torn Ruptured Cartilage	___Torn/Ligaments/Tendons
___Infectious Disease (HIV, Hepatitis, Etc.)		___Osteoporosis

___Other Please List _____
Are you being treated by a physician for any reason? _____
If so, Who? _____
If you are taking any medications please list and indicate what they are prescribed for: _____
_____
Please list tests that have recently been performed and the results, i.e., x-rays, MRI, CAT scan, Nerve Root Block etc.… _____
_____

Major Surgery / Operations: _____
Major Accidents or Falls: _____
Hospitalization (other than above): _____

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If you are seeking bodywork for any purpose such as a chronic pain condition, please list the conditions for which you wish to seek therapy: i.e.… Describe your problem:

_____

_____

Any further comments, explanations or information regarding your health history would be useful.

_____

_____

Are you presently under the guidance of a coach or certified athletic trainer? Yes ( ) No ( )

Do you participate in any of the following?

Activity Frequency (times per week) and Where:

Walking/jogging _____Running_____

Swimming _____Aerobics/weight training _____

Bicycling _____Racquet Sports_____

Skiing_____Yoga_____

Other _____

a) Cancellation Policy: Early notice of cancellation is greatly appreciated. 50% of the session price will be charged if the cancellation is made within 24 hours of the appointment time unless it is for an emergency. If no showing becomes a chronic issue 100% will be assessed.

Please initial b, c, and d, then sign below:

b.) I understand that: I am responsible for my tardiness and that Thom Shenk takes responsibility for late starts when it is his responsibility.

c.) I understand that: I am to notify my massage therapist of any changes in my health care and medical history.

d.) I understand that: This experience is strictly non-sexual. Lewd or sexual language or behavior will not be tolerated and will result in the immediate termination of the session.

I, _____ (print your name), understand that: If I experience any pain or discomfort during this session, I will immediately inform the therapist so that pressure and/or strokes may be adjusted to my level of comfort. I further understand that this therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical adjustments, diagnose, prescribe or treat any physical or mental illness. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there is no liability on the therapist's part should I fail to do so. In the event that I become injured either directly or indirectly as a result, in whole or in part of the aforesaid massage therapist I HEREBY HOLD HARMLESS AND INDEMNIFY the therapist and her principals and agents from all claims and liability whatsoever.

Client Signature: _____Today's Date: _____