Sharalee Hoelscher, RCST®, Certified Advanced Rolfer® (Lic.#MA34039)
4300 Bayou Blvd., #22 Pensacola, FL 850-450-8508

Name_____ Age _____
Address_____
City_____State_____Zip_____
Phone (Home)_____ (Cell)_____ (Work)_____
Emergency Contact_____ Phone _____
Occupation_____Referred by _____
List below ALL Surgeries, include cesarean, cosmetic surgeries, from birth to present
_____
List below ALL Accidents, even if unrelated to current problem, from birth to present
_____
List below ALL Injuries, anywhere in the body, 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_____
Daily stretches, physical therapy, other routine_____
Have you received Rolfing® or Structural Integration before?____ # of sessions_____
Have you received Craniosacral Therapy before?_____ Frequency_____
What do you want help with?_____

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 Rolfing and/or Craniosacral Therapy (CST) and give my consent for Rolfing 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 Rolfing or CST. I understand that Rolfing 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 Rolfing 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_______________