

Maggie Ragatz, Certified Rolfer®, Certified Skillful Touch Massage Therapist
325 Pacific Street, Suite 327a, Morro Bay, CA 93442 (805) 305-0234

Name _____ Address _____

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

DOB _____ Height _____ Weight _____ Occupation _____

Referred by _____ Emergency contact _____

Relationship _____ Telephone (_____) _____

Email address (if you'd like to receive periodic mailings) _____

Do you see a chiropractor? Y / N Name _____ For: _____

Are you under a Physician's care? Y / N For what condition(s)? _____

Physician's name _____ Does your Physician approve of your receiving massage therapy/Rolfing®? Y / N Current medications/supplements: _____

Have you had massage____ or Rolfing____ before? How recently? _____

For massage: Do you prefer deep____ medium____ or gentle____ pressure?

Please circle one: Do you prefer Eucalyptus/Lavender

Please take a moment to carefully read the following information and elaborate below. If you have a specific medical condition or symptom, bodywork may be contraindicated. A referral from your primary care physician (PCP) may be required prior to service being provided. Do you have any history of:

- | | |
|---|--|
| <input type="checkbox"/> Stress or anxiety attacks | <input type="checkbox"/> Depression--Clinical Y / N |
| <input type="checkbox"/> Diabetes--Type 1 / 2 | <input type="checkbox"/> Cancer--In the last 2 years? Y / N |
| <input type="checkbox"/> Frequent headaches/migraines | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart condition |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Arthritis--Rheumatoid? Y / N |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Epilepsy or seizures |
| <input type="checkbox"/> Eczema/psoriasis | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Bruising easily | <input type="checkbox"/> Allergies/MCS |
| <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Respiratory disorders/Asthma |
| <input type="checkbox"/> Mental/Nervous disorder | <input type="checkbox"/> Hepatitis _____ |
| <input type="checkbox"/> Stroke--When? _____ | <input type="checkbox"/> Ulcer/Digestive disorder |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Whiplash --When _____ |
| <input type="checkbox"/> Chronic pain _____ | <input type="checkbox"/> Tendonitis--Where? _____ |
| <input type="checkbox"/> Plantar fasciitis | <input type="checkbox"/> Numbing/tingling pain--Where? _____ |
| <input type="checkbox"/> Broken bones _____ | <input type="checkbox"/> Fatigue/CFS |
| <input type="checkbox"/> Contagious disease | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Other autoimmune issue (e.g. AIDS, Lupus) _____ |
| <input type="checkbox"/> Car accident--When? _____ | <input type="checkbox"/> Other injury or fall _____ |

Please elaborate if you have answered "yes" to any of the previous questions.

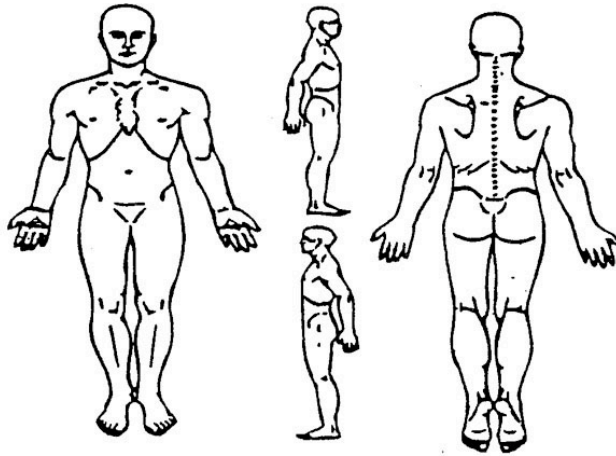
What surgeries, if any, have you had, and when? _____

Do you have an exercise routine? Y / N If yes, what is it? _____

Do you wear Glasses ___ Contacts ___ Neither ___ Are you right or left handed? R ___ L ___
_____ Cigarettes per day/week/month _____ Cups or coffee/tea per day/week
_____ Alcoholic beverages per day/week/month _____ Cups or water per day

For women: Are you pregnant? Y / N Are there complications? Y / N Due ___/___/___

Please describe areas of tension or soreness on the images below.



What is your interest in massage/Rolfing® and what are your expectations? _____

_____ I understand that my massage begins and ends at the prearranged time. If I am late, my bill will remain the same. I understand that I must give 2 hours' notice before a cancellation or I am liable for 1/2 a session's payment. If the practitioner is late, my cost will reflect the reduced session time.

_____ **I understand that if I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my comfort level.**

I further understand that massage therapy or Rolfing should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/Rolfing practitioners are not qualified to perform spinal or skeletal adjustments; diagnose, prescribe, or treat any physical or mental illness; and that nothing said in the course of the session given should be construed as such. Because massage/Rolfing should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances will result in the immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client signature _____ date _____

Practitioner signature _____ date _____

Consent to Treatment of a minor:

By my signature below, I hereby authorize _____ to administer massage or Rolfing to my child or dependent as she deems necessary.

Signature of Parent or Guardian _____ date _____