Bosten Bodywork

A Structural Integration Practice

Client Intake

Name: _____DOB: _____

City/State of residence:_____Contact phone #_____

Emergency contact name/number:_____

What is your occupation?_____

What do you do for exercise?_____

What are your hobbies/interests?_____

Are you currently under the care of a health care provider? If yes, what for?_____

_____

_____

Does your health care provider know you are receiving Structural Integration ? Y N

Describe any surgery, injury, hospitalization or accident you've had especially spine, abdominal or joint related ones:_____

_____

_____

_____

_____

List any medications (herbs, vitamins or pharmaceuticals) you take on a regular basis:

_____

_____

Structural Integration Session

What outcome are you looking for today?_____

_____

Is there anything you don't want me to work on?_____

Are you able to lay on your back, stomach, or L/R sides?_____

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Client Release

I_____, (print name) understand the Structural Integration (SI) I receive is provided for the basic purpose of relief of muscular, myofascial and facial tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that Structural Integration 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 a diagnosis and prescription. I understand that Structural Integration therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said or done in the course of the session be construed as such. Because Structural Integration should not be performed under some specific medical conditions, 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 shall be no liability on the therapist's part should I fail to do so.

Client Signature: _____Date:_____

Under 18 Consent: _____Date:_____

Therapist Signature: _____Date:_____