

CONFIDENTIAL PERSONAL HISTORY FORM AND CONSENT AGREEMENT

NAME: _____ HT _____ WT _____ AGE _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

BIRTH DATE: _____ OCCUPATION: _____

PHONE: H() _____ W() _____ REFERRED BY: _____

Email: _____ SPOUSE OR PARTNER: _____

YOUR GENERAL PHYSICAL STATE AT PRESENT _____

MAJOR PHYSICAL INJURIES/DISABILITIES/ACCIDENTS _____

HISTORY AND DATES OF OPERATIONS _____

ARE YOU PRESENTLY UNDER MEDICAL TREATMENT/ MEDICATION /PRESCRIPTION MEDICINES?

DO YOU OR YOUR DOCTOR BELIEVE YOU HAVE ANY ILLNESS AT THIS TIME?

IN THERAPY (MENTAL OR PHYSICAL)(PAST OR PRESENT)

PHYSICAL DISCOMFORTS (BE SPECIFIC)

SPORTS/ PHYSICAL ACTIVITIES/ INTERESTS

CONTACT LENSES? _____ DIETARY RESTRICTIONS? _____ ALLERGIES? _____

DO YOU HAVE ANY COMMUNICABLE DISEASES? _____

IMPLANTS- MEDICAL, COSMETIC, PHARMACEUTICAL? _____

WHAT ARE YOUR REASONS AND GOALS FOR THE SI WORK?

(Please turn sheet over)

IS THERE ANYTHING RELEVANT TO YOUR SI WORK THAT IS NOT COVERED THUS FAR, PLEASE DESCRIBE HERE:

FOR WOMEN: ARE YOU PREGNANT? _____ DO YOU HAVE AN IUD? _____
NUMBER OF CHILDREN _____ DIFFICULT PREGNANCIES AND/OR BIRTHS?

DIFFICULTY DURING MENSTRUATION/ ANY OTHER PERTINENT INFORMATION

Application and Consent for Structural Integration

I hereby apply for a standard series of processing in Structural Integration.

I fully understand the purpose of Structural Integration is to balance and align the physical body so that it is supported and maintained by gravity in three-dimensional space. This is done through direct manipulation and education so that greater economy and freedom of body-movement is achieved.

I understand Structural Integration is not involved with the treatment of disease of any kind, nor does it substitute for medical diagnosis or treatment when such attention is needed.

The Practitioner of Structural Integration does not treat, prescribe or diagnose an illness, disease, or any other physical or mental disorder of the person. Nothing said or done by the S.I. Practitioner should be misconstrued as to be such.

I understand it is necessary for the S.I. Practitioner to touch my body in order to assist me in establishing balance and alignment in my body.

I give Scott Gauthier my permission and consent to do all those things necessary in helping me establish balance and alignment, including but not limited to touching my body. I give the Practitioner full privilege and license to work on my body in such a way as to restore and establish balance and alignment therein.

Furthermore, I understand that any relief of physical or emotional symptoms is coincidental in the organization of the total human being and is not the basic goal of Structural Integration.

Signed: _____ Date: _____

Witness: _____

Fee and Cancellation Policy

The agreed upon fee for each session is _____. Notes: _____

You have reserved a special time for us to work together. The time that I spend working on your behalf includes more than just the time we are together. I often research, meditate, and ask for spiritual help on your behalf before the session. Therefore I must ask for payment in the case of cancellation.

I understand that I am liable for payment for sessions that I cancel.

Name: _____ Date: _____