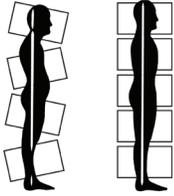


Body Solutions R.E.i. Method



Date _____

Name

Age

E-Mail

Address

City

State

Profession

Cell Phone

Zip Code

CLIENT INFORMATION IS CONFIDENTIAL

Skip any questions that do not apply to you.

Have you previously had bodywork? If so, what kind? Massage, Chiro, etc.

What results do you want or expect?

Do you have a specific physical condition you want to improve?

Do you have a specific emotion pattern you want to improve?

Do you experience any type of stress, anxiety, or fear? Mild, moderate, severe?

Do you think there is a connection between your physical condition and your emotional well being?

Body Solutions

R.E.i Method

What activities do you enjoy doing for yourself? How often?

Walking

Gym

Swimming

Surfing

Running

Tennis

Golf

Other Sports

Meditation

Pilates

Yoga

Dance

Other

Hobbies

Circle problem areas

Do you experience any of the following?

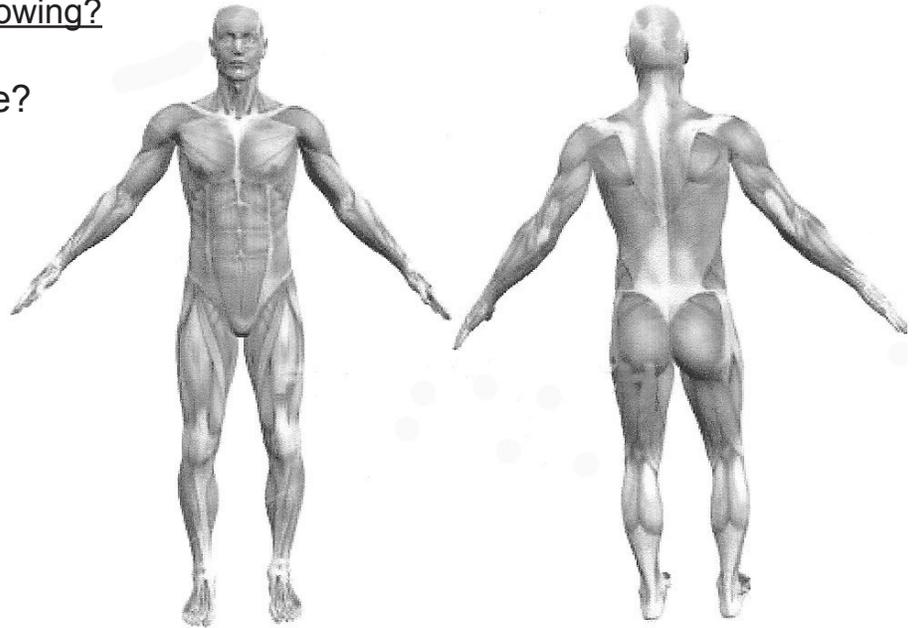
Posture of alignment imbalance?

Restriction in movement?

Tension?

Accidents?

Surgery?



Trauma: Painful physical or emotional event? _____

Yes, but I would rather not talk about it.

Rate each item on a 1-10 scale, 1 being low or problematic, 10 being high or most positive.

1. Health _____
2. Well-being _____
3. Energy Level _____
4. Freedom from tension and pain _____

5. Knowledge or awareness of your body _____
6. Ability to deal with stress as it arises _____
7. Expressing your emotions _____
8. Self esteem _____

Is there anything else you would like to discuss?

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Consent for Structural Integration or Bodywork

I consent to a session - or a series of sessions by Michael Mitchell who has explained to me the general process of Structural Integration. The purpose being to realign, rebalance, and repattern the body.

I understand that the practitioner does not treat, prescribe, or diagnose any illness, disease, or any other physical or mental disorder, injury, or condition.

I understand that I am in control of the pressure brought to bear on my body, and that I am responsible for communicating with the practitioner if the pain or pressure is creating too much discomfort.

I agree to keep the practitioner updated on changes in my health and understand there shall be no liability on the practitioner's part should I fail to do so.

I understand that it is necessary for the practitioner to touch my body in order to assist me in establishing balance and alignment. I give Michael Mitchell my permission to use learned techniques in order to help me to restore balance and alignment.

If desired, photographs may be requested by the client for the purpose of serving as visual aids as a way to help establish awareness of posture habits. Photographs may be taken before and after sessions to show structural changes.

I agree to pay for any appointment that I miss or do not cancel 24 hours in advance.

Signature

Date

Signature of parent -if client is a minor

Session Notes for Practitioner

Intake

Sleeve Sessions

1

2

3

Core Sessions

4

5

6

7

Integrative Sessions

8

9

10