New Patient Information Form
Confidential Internal Use Only

Phone# 720-261-8002 E-mail appt@rolfpros.com

(All information is kept confidential) Today's Date:_____

Patient Full Name:_____ Date of Birth:_____

Address:_____ E-mail:_____

City:_____ State:_____ Zip:_____ Phone:_____

How would you like to be addressed:_____

Gender: M or F (Just circle) Are you Married, Single, Widowed, Divorced? (Just circle)

Is it ok to send you text msgs (SMS) to your cell phone? Y or N (Just circle)
Is it ok to send you an e-mail? Y or N (Just circle)

(For appt reminder, schedule appt on-line, possible openings, or social media / blog updates / newsletter)

If it applies, who is your insurance provider? _____

Insurance ID Card#_____ Phone#_____

Your Emergency Contact Person:_____ Relationship:_____

Address:_____ E-mail:_____ Phone#_____

Patient Signature:_____ Date:_____

Guardian Signature:_____ Date:_____
(If Under Age 18)

If you have a specific medical condition or specific symptoms, FMS™ Test, Rolfing®, manual therapy, RockTape™ fascia taping, & LiteCure LightForce® Pro laser therapy may be contra indicated. A written referral from your primary care provider may be required. I understand that FMS™ Testing, Rolfing®, manual therapy, RockTape™ fascia taping, & LiteCure LightForce® Pro laser therapy should not be construed as a substitute for a medical exam or diagnosis. You should consult a physician for any physician for any mental or physical illness. Because FMS™ Test, Rolfing®, manual therapy, RockTape™ fascia taping, & LiteCure LightForce® Pro laser therapy should NOT be performed under certain conditions, I affirm that I have stated all my known medical, and answered all the questions below honestly. I agree to update Fred Nehring & RolfPros.com LLC as to any changes in my medical profile and understand that there shall be no liability to Fred Nehring's or RolfPros.com, LLC part should I forget to do so. A 24hr notice is required for all cancellations to avoid a cancellation fee of $135.00 unless it's an emergency. I will allow you to substitute with someone else to avoid the $135.00 charge. Payment a minimum of four (4) sessions for a total of $500.00 unless offset by insurance or special offer. All four (4) RolfPros packs require a deposit of half the amount down and the remaining balance due at the end of each session. Payments are done by either cash, check, or credit card and are due at the end of each session. I understand that FMS™ Test, Rolfing®, manual therapy, RockTape™ fascia taping, & LiteCure LightForce® Pro laser therapy may be physically strenuous and I voluntarily participate in them with full knowledge that there is personal risk. I agree to keep Fred Nehring & RolfPros.com LLC, informed of any discomfort either physically or emotionally during or after a completed session. All information on this form will be kept CONFIDENTIAL and used to provide you with the best treatment. It will NOT be shown or given to anyone without your written permission. With your authorization you maybe asked for a testimonial to be used in advertising, marketing or other media outlets. Upon your approval I hereby grant permission to Fred Nehring & RolfPros.com, LLC and to interview me and / or to use my name and likeness in testimonials, photographs or videos in any and all of its publications and in any and all other media, whether now known or hereafter existing, controlled by Fred Nehring & RolfPros.com, LLC in perpetuity, and for advertising, marketing, or other used by Fred Nehring & RolfPros.com, LLC. I hereby release Fred Nehring & RolfPros.com, LLC from all liability from use of such interviews, testimonials, photographs, or videos.

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What is your main complaint or pain issue?

_____

_____

Type of condition: Aching Burning Cramping Dull Throbbing Numbness Tingling etc:_____

Severity (1-10):_____ How long: _____ Do you notice it more in the AM or PM? (Just circle)

Is it accident related? Y or N. Auto, Work, Home, Community (Just circle)

*Explain:_____

_____

_____

What are your goals for the Rolfing®SI series?_____

_____

_____

Have you tried any other form of healing method? Like physical therapy, chiropractic care, acupuncture, massage therapy, or other. Y or N. Please explain: _____

_____

Have you had previous physician's care for this pain? Y or N. My I contact your physician? Y or N.

Their Name/Ph#/Email__

_____

Please check all conditions you have suffered or been diagnosed with: (please circle left or right if it applies)

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___*Fractured bones	___*Surgeries	___*Foot trouble L R
___*Auto accidents	___*Neck pain / stiffness L R	___*Chest pain or asthma
___*Other accidents	___*Numbness / tingling, pain in arms, legs, hands, feet, head, butt, toes	___*Trouble breathing
___*Arthritis	___*Jaw pain or clicks L R	___*Heart / circulatory problems
___*Fibromyalgia	___*Difficulty in standing, sitting, bending, twisting, lifting, walking running, exercises	___*Pacemaker
___*Diabetes	___*Shoulder pain L R	___*Stroke
___*IBS	___*Dizziness	___*High / low blood pressure
___*Convulsions, seizures	___*Ringing in ears L R	___*Varicose veins
___*Skin problems	___*Hearing loss L R	___*Liver trouble
___*Cancer	___*Blurred or doubled vision	___*Gall bladder trouble
___*Frequent colds, flu	___*Upper back pain, stiffness	___*Digestive problems
___*Depressed / Irritable	___*Mid back pain	___*Ulcers
___*AIDS / HIV	___*Lower back pain stiffness	___*Hemorrhoids
___*Anemia	___*Hip pain	___*Prostate problems
___*Allergies	___*Headaches	___*Impotence
___*Under stress	___*Blood cough / sneeze	___*Kidney trouble
___*Eating disorders	___*Head trauma	___*Tumors / Congenital problems
___*Trouble concentrating	___*Steroid Injection in past 7 days	___*PMS
___*Learning disability	___*Cortisone Injection	___*Bed wetting
___*Mood changes		___*Pregnant
___*Epilepsy		___*Ear / sinus infections
___*Taking medications including any that are sensitivity to light		___*Alcohol or drug addiction
		___*Smoke

*Explain:_____
_____
_____

Are there any medications, vitamins, or supplements that your currently taking? Y or N.

Please explain:_____
_____
_____
_____
_____
_____

Is there any other pain, injury, or condition that you think I should know about? Y or N.

Please explain:_____
_____
_____
_____
_____

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Release Of Confidential Information Form

I, _____ authorize the release of information, including medical/psychological/chiropractic/athletic trainers/physical therapist/rolfers™/ advanced rolfers™/occupational therapist, pilates instructors, professional counselors records, between the following providers:

1. RolfPros.com, LLC (Fred Nehring, Certified Rolfer™, HHP)
2. Other:_____

Dates Covered:

1. ” All rendered care at this facility or by this provider.
2. ” From ____/____/____ to ____/____/____ Information Released:
    1. ” New Patient Information Form
    2. ” Rolf Pros SOAP Notes
    3. ” Other_____

This authorization will be in effect unless otherwise notified.

Patient’s Signature:_____ Date: _____

If under age 18, Guardian Signature: _____

Witness: _____

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Release For Litecure LightForce® Pro Laser Therapy

Litecure LightForce® Pro laser therapy is a safe, non-invasive, FDA cleared modality for the treatment of pain and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic pain conditions. Litecure LightForce® Pro laser therapy utilizes visible and invisible laser photons, therefore, appropriate eye protection s required at all times during treatment.

You should consult a physician for any physician for any mental or physical illness. Because Litecure LightForce® Pro laser therapy should **NOT** be performed under certain medical conditions, I affirm that I have stated all my known medical, and answered all the questions in the intake form honestly. I agree to update RolfPros.com LLC, as to any changes in my medical profile. By signing this release for Litecure LightForce® Pro laser therapy I understand that there shall be no liability to RolfPros.com LLC from any damages that could occur to me. I understand that failing to complete any part of my Litecure LightForce® Pro laser therapy treatment program will reduce my chances of success.

Effects of your treatment will continue for up to 18 hours. Individuals respond uniquely to treatment, you may see immediate results after the first treatment or depending on the severity of your condition you may require several treatments before you begin to feel results. Increased soreness may occur after your first Litecure LightForce® Pro laser therapy session. This is normal due to cellar change occurring in the body.

This authorization will be in effect unless otherwise notified.

Patient's Signature:_____ Date: _____

If under age 18, Guardian Signature_____

Witness: _____