

Elizabeth Keith Movement Education, LLC
Elizabeth Keith, Guild Certified Feldenkrais Practitioner^{cm}
CONFIDENTIAL CLIENT/PATIENT INFORMATION

Name _____ Age _____ Birthdate _____ Sex: M F

Address _____ City _____ State _____ Zip _____

Phone _____ Mobile Phone _____ E-mail _____

Who to Contact in Case of Emergency: _____ Their Phone Number _____

How were you referred to this office? _____

Doctor's Name _____ Phone _____

Please give a brief history of your current problem:

What would like to achieve by coming to see me?

What else are you doing to help with this situation?

Do you have any special concerns or needs you would like me to know?

What kind of work do you do?

Any Injuries, including childhood? (please list dates and description,)

Any Surgeries, including childhood? (please list dates and description)

Any Extensive Dental Work, including childhood? (please list dates and description)

Do you currently participate in an exercise program? If "Yes", please describe briefly

Have you ever suffered from?: (Check all that apply)

- Arthritis
- Varicose Veins/Phlebitis
- Cancer (please, specify) _____
- Blood Clots
- Osteoporosis
- Headaches
- Numbness (please, specify) _____
- Backaches (please, specify) _____
- Spinal Fusions (please, specify) _____
- Skin Conditions (please, specify) _____
- Heart Problems
- High Blood Pressure
- HIV/AIDS
- Diabetes
- Mental Illness
- Allergies (medications, plants, foods, topical substances....)

If NONE, please check: NO ALLERGIES _____

Please List Medications you are Currently Taking _____

I, _____, understand that the Feldenkrais Method® is system designed for educational purposes only. Lessons are designed to teach awareness of how you move, your habitual movement patterns and options for movement in daily life activities. I understand that the Feldenkrais Practitioner does not diagnose illness, disease, or any other physical or mental disorder and that Feldenkrais Lessons are not to be substituted for medical care. Because a Feldenkrais Practitioner must be aware of existing medical conditions, I have stated all my known medical conditions and will keep the Feldenkrais Practitioner notified of any changes in my medical condition.

CANCELLATION/ NO SHOW/ LATE POLICY

The time of your appointment is reserved for you. As a courtesy to you and other clients, it is our policy to start your appointment on time. Late arrivals will receive only the time remaining on their scheduled appointment and will be responsible for the entire fee. Appointments cancelled or rescheduled with less than 6 hrs. notice will be charged a fee equal to 50% of the standard charge for the appointment. "No Shows" will be charged for the full cost of the appointment or will forfeit the appointment in cases where it has been prepaid. These fees will be charged directly to and are the responsibility of the client.

Signature _____ Date _____