*Feldenkraisinsarasota.com* *Bonnie Kissam, M.A.,* *Feldenkrais® Practitioner* LMT, Lic # 36256

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_e-mail \*\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_

Phones: home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ work \_\_\_\_\_\_\_\_\_\_\_\_\_\_ cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of work engaged in daily ( sitting, lifting, playing an instrument, reading, exercise)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Interests:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list accidents or operations ( approx dates):

Present symptoms: What is your major complaint or condition you would like to improve?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you first notice major complaints? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What activities aggravate the condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does this condition interfere with work? Y N S Sleep? Y N S Daily Routine? Y N S

What offers relief?

Has there been a medical diagnosis? o Yes o No

If so, when?

Have you had X‑rays taken? o Yes o No

Please list any medications (including aspirin) you are taking:

Please list other therapies you receive:

Please list any additional comments regarding your health and well‑being:

What are your intentions or expectations for this visit?

Who referred you to the *Feldenkrais Method or to Bonnie* ? Name:

o Yellow Pages o Advertisement o Sign o Other:

Please sign the following statements:

*I fully understand that the Feldenkrais Method is about my personal learning.*

*I agree to take full responsibility for myself in this process.*

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I give my permission for Bonnie to contact me through email for appointments, workshop/class alerts and her monthly newsletter.*

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_