

**Rolfing® Intake Form**

Name (Print) \_\_\_\_\_ Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

How were you referred to my office? (Referral/Yelp/Google/etc.) \_\_\_\_\_

Have you been Rolfed? Yes \_\_\_ No \_\_\_ How many sessions? \_\_\_\_\_ By whom? \_\_\_\_\_

Are you under the care of a physician? \_\_\_\_\_ For what condition? \_\_\_\_\_

Are you on any medication prescribed by a physician? Yes \_\_\_ No \_\_\_ What: \_\_\_\_\_

Do you use aspirin or other non-prescription drugs? Yes \_\_\_ No \_\_\_ What type/How often: \_\_\_\_\_

Are you involved in psychotherapy? Yes \_\_\_ No \_\_\_

Are you involved in an exercise program? Yes \_\_\_ No \_\_\_ Describe: \_\_\_\_\_

**Women:** Are you pregnant? Yes \_\_\_ No \_\_\_ Do you have an I.U.D.? Yes \_\_\_ No \_\_\_

<b>ANY HISTORY OF:</b>					
	Yes	No		Yes	No
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer/Digestive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Mental/Nervous Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Genito-Urinary Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>

Please elaborate on any yes answers to the history above: \_\_\_\_\_

Do you have radiating pain in any limbs? Yes \_\_\_ No \_\_\_ Numbness or tingling? Yes \_\_\_ No \_\_\_

Explain: \_\_\_\_\_

Do you have any known issues of the feet, ankles, knees, hips or back? Yes\_\_\_\_\_No\_\_\_\_\_Explain\_\_\_\_\_

Do you have any known digestive issues or concerns? Yes\_\_\_\_\_No\_\_\_\_\_Describe\_\_\_\_\_

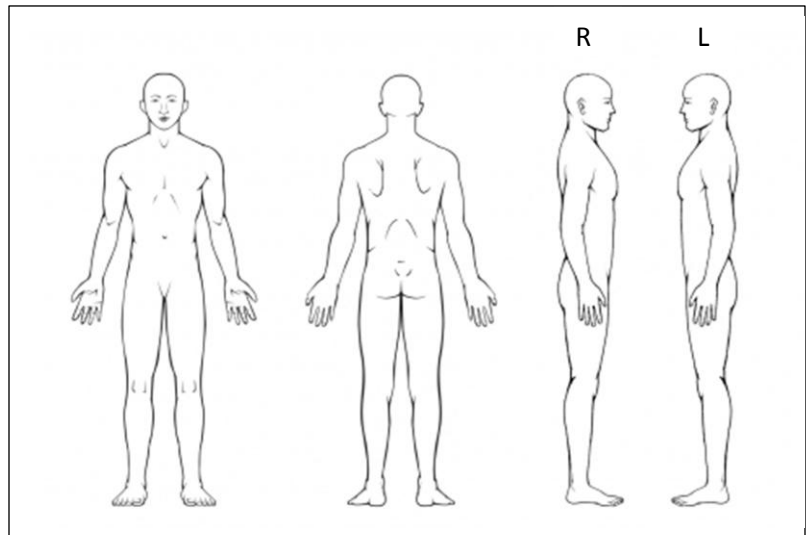
Please list any operations or injuries that you have had:\_\_\_\_\_

What is your primary reason for this office visit?\_\_\_\_\_

- How long ago did the issue start?\_\_\_\_\_ Frequency:\_\_\_\_\_
- What relieves the symptom(s)?\_\_\_\_\_
- What exacerbates the symptom(s) (what makes it worse)?\_\_\_\_\_

Please list any secondary complaints and/or goals for receiving Rolfing?\_\_\_\_\_

Please circle on the diagram to the right where your primary source of pain is showing up. Please put a "P" next to primary and an "S" next to any secondary concerns.



I fully understand the purpose of Rolfing 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 of body-movement is achieved. I understand Rolfing 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 Rolfer does not treat prescribe or diagnose an illness, disease, or any other physical or mental disorder of the person. Nothing said or done by a Rolfer should be misconstrued to be such. I understand it is necessary for the Rolfer to touch my body in order to assist me establishing balance and alignment in my body.

I give **Christopher Horan** my permission and consent to do all the things necessary in helping me establish balance and alignment, including, but not limited to touching my body. I give the Rolfer 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 human being and is not the goal of Rolfing.

**IN CASE OF CANCELLATION!** I agree to give 24 hours advance notice of scheduled session, or to assume full responsibility for payment of the full fee.

SIGNED:\_\_\_\_\_DATE:\_\_\_\_\_

WITNESS:\_\_\_\_\_DATE:\_\_\_\_\_

(Parent or guardian of minor)