Christopher Horan
Certified Rolfer™

Rolfing® Intake Form

Name (Print)________________________________Email:______________________________Phone:______________________

Address:____City:__________________State:_________Zip:__________________

Occupation:____Date of Birth:_______________________________

How were you referred to Rolfing?____

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____For how long?____

Describe:____

Women: Are you pregnant? Yes______No_____

ANY HISTORY OF:

	Yes	No		Yes	No
Heart Condition	◻	◻	Cancer	◻	◻
High Blood Pressure	◻	◻	Diabetes	◻	◻
Arthritis	◻	◻	Respiratory Disorder	◻	◻
Osteoporosis	◻	◻	Asthma	◻	◻
Ulcer/Digestive Disorder	◻	◻	Epilepsy	◻	◻
Mental/Nervous Disorder	◻	◻	Phlebitis	◻	◻
Genito-Urinary Disorder	◻	◻	Birth Defects	◻	◻

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:____

Continued on reverse side……..

Eye, ear, nose or throat disorder?____

Do you have any disability of the feet, ankles, knees, hips or back? Yes________No____Explain____________________

____

Do you have any chest pains during exertion? Yes_____No____Describe______________________________________

____

Please list any operations, accidents, injuries or serious illness that you have had:____________________________

____

Do you have any contagious or communicable disorders? Describe:____

Do you have any chronic complaints? (things you have given up on and accepted, i.e., headaches, constipation, etc.)____

____

Do you feel tired very often? Yes______No_____ How do you relax?_______________________________________

Do you drink coffee? Yes______No____ How many cups per day?_____

Do you drink alcoholic beverages? Yes________No____ How often?____

Why do you want to be Rolfed, and what are your expectations?____

____

Additional information and/or comments you would like to add:____

____

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.

<u>**IN CASE OF CANCELLATION!**</u> 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)