New Client- Intake Form

Name (Print)_____ Phone ( )_____ Date of Birth_____

Address_____City_____State_____Zip_____

Email _____

Occupation_____ What brings you to Rolfing and what do you hope to experience from the work?_____

How did you hear about me? (*ie- yelp/Rolf Institute website/google search/walk by/referral*)

_____ Have you been Rolfed? Yes __ No __ How many sessions? _____

Are you under the care of a physician? _____ For what condition(s)? _____

Does he/she approve of your being Rolfed? _____

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 and how often?_____ Are you currently involved with any type of physical or mental therapy? (acupuncture, psychotherapy, massage, etc) _____

Do you exercise? Yes ___ No __ What kind of exercise and how often?_____

What is your diet generally like? _____

How do you like to relax? _____ Do you feel tired very often? _____

How is your sleep at night? _____ What are stressors in your life right now? _____

How does your livelihood or your habits/hobbies affect your body? _____

_____

Do you have any chronic complaints? (things you have accepted as a constant, ie headaches, constipation, anxiety)?

_____

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

_____

_____

_____

For Women: Are you pregnant? Yes___ No___

ANY HISTORY OF:

Please check all that apply to you.

___Heart Condition	___Cancer	___Genito-Urinary Disorder
___High Blood Pressure	___Diabetes	___Multiple Sclerosis
___Arthritis	___Asthma	___Mental/Nervous Disorder
___Osteoporosis	___Epilepsy	___Respiratory Disorder
___Ulcer/Digestive Disorder	___Birth Defects	

Please elaborate on any checked answers to the history above

_____

_____

New Client- Intake Form

What is something you value about your current structure and/or body? _____

What are 3 wishes for your 10 series or Rolfing experience? _____

_____

_____

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

_____

_____

I fully understand the purpose of Rolfing Structural Integration 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 in establishing balance and alignment in my body.

I understand that Rolfing Structural Integration is a process and is not effective as a "quick fix" for chronic complaints. This process is interactive and requires practice and awareness from the client.

I understand that this work is most effective if the assigned "homework" and practices are incorporated into daily life.
IN CASE OF CANCELLATION: *I agree to give 24 hours advance notice of scheduled session, or to assume responsibility for payment of half the session ($55.)*

SIGNED_____ DATE_____