Rolfing – Client Intake Form

Personal Information

Name
Address
City, State, Zip
Email
Phone (day): (cell):
Date of Birth
Occupation

Emergency Contact

Name
Phone
Relation to Client

General Information
Height Weight
Have you ever had a Rolfing session before? **Y/N**
If yes, for what condition?

What would you like to gain from your Rolfing sessions?

Are you sensitive to fragrances or perfumes? **Y/N**
Do you wear contact lenses? **Y/N**
Describe your daily activities (work, exercise):

What is your general diet?

Do you:
□ smoke cigarettes □ consume alcohol
□ drink caffeinated beverages

Medical History
Do you suffer from chronic pain/discomfort? **Y/N**
If yes, where?

Do you know the cause?

When do symptoms seem to get worse or better?

Are you currently under the care of a health practitioner, physical or psychotherapist? **Y/N**
If yes, for what condition?

Please indicate conditions that you have had/currently have:

□ headaches, migraines
□ allergies, sensitivity
□ arthritis, osteoporosis
□ cancer, tumors
□ TMJ problems
□ abnormal skin condition
□ heart/circulation problems
□ joint replacement / surgery.
Please provide year and details:

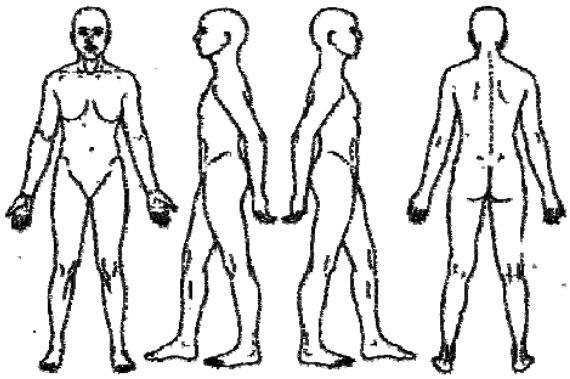
□ high / low blood pressure
□ major accident.
Please provide year and details:

□ athlete's foot
□ stroke. **Year:**
□ varicose veins
□ pregnancy
□ blood clots
□ neck / back injuries.
Please provide year and details:

□ diabetes
□ paralysis
□ fibromyalgia
□ numbness, sprains, strains. **Area(s):**

List any medications you are currently taking and the conditions they are for:

Note area(s) of common pain or tension below



Explain any conditions or surgeries that you have marked above or that are not listed:

Informed Consent and Policies
I understand that the Rolfing sessions I will be receiving is for therapeutic purposes and is non-sexual. I understand that the purpose of receiving Rolfing sessions is to assist in balancing and aligning the physical body through direct manipulation, appropriate contact and education to achieve increased freedom of movement.

I understand that the Rolfer makes no warranties or guarantees as to the results of the Rolfing process and give consent for the practitioner to apply appropriate physical contact to my body. I understand that if I experience any unusual discomfort and/or pain during my session, it is my responsibility to actively communicate this to the practitioner so that he/she can adjust the pressure or technique being used, or if necessary, end the session. I may also, at any time, request to terminate the session.

I understand that the practitioner does not diagnose illness, disease, or any further physical or mental disorders and the session should not be a substitute for medical treatment or diagnoses from a medical professional when such attention is required.

I acknowledge that the information I have provided on this form is correct and current to the best of my knowledge. I acknowledge that I have provided a truthful and accurate medical history. I understand that it is my responsibility to inform the practitioner of any changes to this information.

Cancellation Policy
I acknowledge that a minimum 24-hour cancellation notice **by phone** prior to my scheduled appointment is required. I acknowledge that I will be billed in full for the cost of a session for any cancellations made within 24 hours of my scheduled appointment. I agree to be responsible for full payment of the charges per the cancellation policy. ***Your appointment time has been set aside especially for you. If you are unable to keep the appointment, please consider providing enough notice so others who are waiting have the opportunity to reserve that time.***

Privacy Policy
All written records and sessions are kept strictly confidential and will not be shared with any outside establishment, individuals, organizations, or medical facilities without explicit written consent from the client (you) or the client's legal guardian, unless legally required by local, state, or federal subpoena, summons, or other court order.
I acknowledge that I understand my rights as the client receiving services. I am aware that I can request an additional copy of this document at any time.

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Client Signature Date