ROLFING INTAKE FORM

NAME_____

PHONE - WORK_____PHONE – HOME_____PHONE – CELL_____

ADDRESS_____

OCCUPATION_____ HEIGHT _____ WEIGHT _____

DATE OF BIRTH _____ EMAIL ADDRESS_____

HOW WERE YOU REFERRED TO ROLFING?_____

HAVE YOU BEEN ROLFED? NO___YES___ # OF SESSIONS____ BY WHOM _____

IF YOU ARE UNDER THE CARE OF A PHYSICIAN, DO YOU HAVE THEIR APPROVAL FOR ROLFING?

ARE YOU ON ANY MEDICATION PRESCRIBED BY A PHYSICIAN? NO_____YES_____
WHAT_____

DO YOU USE ASPIRINS OR ANY OTHER NON-PRESCRIPTION DRUGS? NO____YES_____
WHAT TYPE AND HOW OFTEN? _____

ARE YOU INVOLVED IN PSYCHOTHERAPY? NO___YES___ WHAT TYPE

ARE YOU INVOLVED IN AN EXERCISE PROGRAM? NO___YES___ FOR HOW LONG? _____
DESCRIBE_____

HAVE YOU EVER WORN BRACES? YES ___ NO___ WEAR CONTACT LENSES? YES___ NO___
WOMEN: ARE YOU PREGNANT? YES ___ NO___

ANY HISTORY OF:

HEART CONDITION	CANCER	MENTAL/NERVOUS DISORDER	EPILEPSY
HIGH BLOOD PRESSURE	DIABETES	GENITO-URINARY DISORDER	PHLEBITIS
ARTHRITIS	RESPIRATORY DISORDER	LCER/DIGESTIVE DISORDER	ULCER/DIGESTIVE
OSTEOPOROSIS	ASTHMA	BIRTH DEFECTS	

DO YOU HAVE RADIATING PAIN IN ANY LIMBS? YES ___ NO___
NUMBNESS OR TINGLING YES___ NO___

EXPLAIN _____

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 CHEST PAINS DURING EXERTION? YES___ NO ___

DO YOU HAVE ANY ILLNESS OR INJURY AT THE PRESENT TIME? YES ___NO ____
DESCRIBE_____

SUZANNE STONE, CERTIFIED ADVANCED ROLFER 239-642-0101

ROLFING INTAKE FORM

PLEASE LIST ANY SURGERIES, ACCIDENTS, INJURIES OR SERIOUS ILLNESS THAT YOU HAVE EXPERIENCED_____
_____

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 LIKE SUGAR? YES___ NO____ DO YOU CONSUME SUGAR EVERY DAY? YES ___ NO ___

WHY DO YOU WISH 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 CLIENT. 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 GIVE (WRITE ROLFER'S NAME) _____MY PERMISSION AND CONSENT TO DO ALL THOSE 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 Y 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 TOTAL 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 RESPONSIBILITY OF PAYMENT OF FULL FEE.

SIGNED _____DATE_____

WITNESS_____DATE_____

SUZANNE STONE, CERTIFIED ADVANCED ROLFER 239-642-0101