

LIBBY EASON

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ROLFING® STRUCTURAL INTEGRATION: Intake Form

Name (Print) _____ Phone-Work/Cell () _____ Home () _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Height _____ Weight _____

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? ___ 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 involved in psychotherapy? Yes ___ No ___

Are you involved in an exercise program? Yes ___ No ___ For how long? _____

Describe _____

Have you ever worn braces? Yes ___ No ___ Do you wear contacts? Yes ___ No ___

Women: Are you pregnant? Yes ___ No ___

ANY HISTORY OF:	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 _____

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 ___

Do you have any illness or injury at the present time? 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? _____

Do you like sugar? Yes ___ No ___ Do you use sugar every day? Yes ___ No ___

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 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 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 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 for payment of the full fee.*

SIGNED _____ DATE _____

WITNESS _____ DATE _____

(Parent or guardian of minor)