LIBBY EASON
Certified Advanced Rolfer® and Rolf Movement Practitioner
404-315-0099

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?_____ Date of last session _____

Are you under the care of a physician(s)? Yes☐ No☐ For what condition? _____

Do they approve of your being Rolfed? Yes☐ No☐ Are you on any physician-prescribed medication? Yes☐ No☐

If Yes, what? _____

Do you use aspirin or other non-prescription drugs? Yes☐ No☐ If Yes, what type(s) and how often? (*list below*)

_____

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	☐	☐	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☐

Describe_____

Form cont. on reverse side…

Eye, ear, nose or throat disorder? Yes ☐ No ☐ Describe_____

Do you have any disability of the feet, ankles, knees, hips or back? Yes ☐ No ☐ Describe _____

_____

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 illnesses you have had _____

_____

Do you have any contagious/communicable disorders? Yes ☐ No ☐ 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 **Libby Eason** 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 privelege 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)