



**CLIENT INTAKE FORM**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Referred by \_\_\_\_\_

Past or Current: I have had the following: Injuries Accidents Surgeries Birth Trauma

Comments: \_\_\_\_\_

Current medications: \_\_\_\_\_

List any types of health care or medical treatment you are currently receiving: \_\_\_\_\_

Circle any of the following that apply to your current or past health:

- |             |                    |            |                     |
|-------------|--------------------|------------|---------------------|
| Pregnancy   | Heart Condition    | Cancer     | High Blood Pressure |
| Blood Clots | Breathing Problems | Arthritis  | Skin Conditions     |
| HIV/AIDS    | Balance Problems   | Infections | Major Illness       |
| Injuries    | Accidents          | Surgeries  | Birth Trauma        |

Comments: \_\_\_\_\_

Occupation \_\_\_\_\_ Stress Level \_\_\_\_\_

Exercise type and frequency \_\_\_\_\_

Have you received Rolfing® or Structural Integration before? \_\_\_\_ # of sessions \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

**CONSENT FOR CARE**

It is my choice to receive Rolfing® structural integration. I am aware of the benefits and risks of Rolfing SI and give my consent for Rolfing SI. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I understand that Rolfing SI is not involved with the treatment of disease, illness, or disorders of any kind, nor is it a substitute for medical diagnosis or treatment when such attention is needed. Likewise, Rolfing practitioners do not diagnose or treat any illness, disease or other physical or mental disorder of the person I understand that any relief of physical or emotional symptoms is coincidental to the Rolfing SI process and is not a goal of Rolfing. I understand that medical insurance may not pay for Rolfing SI and agree to be responsible for the cost of my appointment at the time of treatment.

Signed \_\_\_\_\_ Date \_\_\_\_\_