CHARLES HUNG
CERTIFIED ROLFER

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_____

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