Rolfing and Movement
Intake Form

General Information

Date: ___________ How did you hear about my practice? ______________________________

Name: ____

Address: _____________________________ City: _____________ State: _____ Zip: ________

Age: ______________ Occupation: ____

Phone: ________________________Email:____

Emergency Contact Name: ___________________________ Phone: ______________________

Medical History

1. Please circle any current medical conditions.

Allergies	Depression	Multiple sclerosis
Anxiety disorder	Diabetes	Numbness/tingling
Asthma	Dizziness/fainting	Osteoporosis
Arthritis	Fibromyalgia	Other: _______________
Blood clots	Headaches/migraines	Pregnancy
Bruising	Hepatitis	Seizures/epilepsy
Cancer	Hernia	Skin condition
Chemical dependency	High/low blood pressure	Stroke
Circulation problems	HIV/AIDS	Varicose veins

2. Are the conditions circled above being managed with medication and/or with the help of a medical professional? If not, please explain.

____

3. List any surgeries you have had and the dates.

____

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4. List any injuries or accidents you have had and the dates.

____

5. List any prescriptions medications you currently take and their purpose.

____

6. List any regular exercise activities.

____

7. Have you received Rolfing or bodywork before? If so describe:

____

8. Indicate what kind of pressure you prefer:

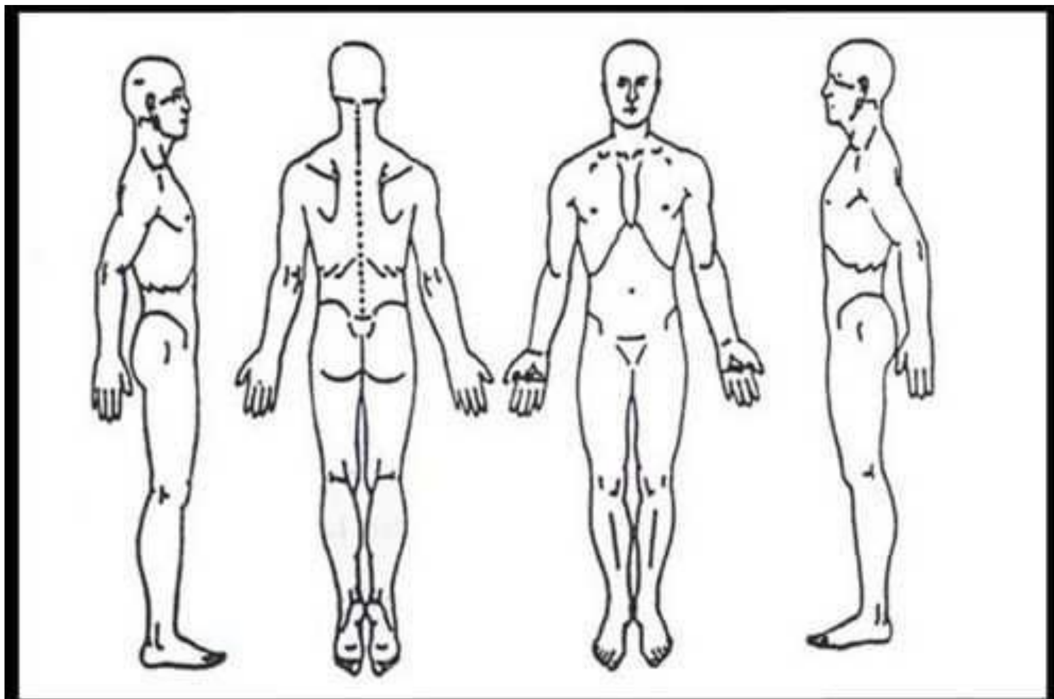
Light   Light-Moderate   Moderate   Moderate-Deep   Deep

7. Describe what brings you in today, including symptoms and date/mechanism of onset.

____

____

8. Indicate areas of pain or discomfort on the diagram below.



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Rolfing and Movement
Consent Form

Consent for Treatment

- ☐ I understand that the purpose of Rolfing is to balance and align the body in gravity. This is done through hands-on manipulation of the body's soft tissues—muscles and fascia—to achieve greater efficiency and ease of movement.

- ☐ I understand that Rolfing should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware.

- ☐ Because Rolfing should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated on changes in my health and understand that there shall be no liability on the practitioner's part should I fail to do so.

- ☐ I understand that if I experience any pain or discomfort during the session, I should immediately inform the practitioner so that the pressure may be adjusted to my level of comfort.

Financial Policy

- ☐ I agree to give 24 hours notice if I must cancel an appointment. If I do not give 24 hours notice, I understand that I will be charged 50 percent of the cost of the session.

- ☐ I agree to pay $170 in cash, check, or credit card at the time of service for a 75-minute Rolfing session.

I understand and agree to the Financial Policy and Consent for Treatment above and will abide by its terms.

Signature: ____ Date: ________________

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