Embody Freedom Rolfing Intake & Agreement Form

Name_____Date of Birth_____

Street_____City_____

State_____ Zip_____Email_____

Phone (cell)_____Work_____

Referred by _____

Are you currently in pain or discomfort?

_____

Medical History

Please give a brief description of any that you have experienced

- ☐ Arthritis
- ☐ Broken bones
- ☐ Osteoporosis
- ☐ Severe sprains
- ☐ Radiating pain/joint pain
- ☐ Numbness or tingling
- ☐ Heart condition
- ☐ Autoimmune disorders
- ☐ Asthma/other respiratory problems
- ☐ Sinus infections/allergies
- ☐ Pregnancies
- ☐ Tinnitus
- ☐ Contact lenses
- ☐ TMJ pain/teeth grinding
- ☐ Whiplash
- ☐ Surgeries
- ☐ Concussions
- ☐ Skin conditions
- ☐ Diabetes
- ☐ Headaches
- ☐ Digestive disorders
- ☐ Depression
- ☐ Cancer
- ☐ Sleep disturbances or insomnia
- ☐ Car or bike accidents
- ☐ Other injuries or illness

If other, please list

_____

Please list current medications:_____

_____

Please list your other healthcare practitioners:_____

_____

I understand that the purpose of Rolfing is to balance and align my body so that I may live with greater freedom. These goals are accomplished through manipulation and education – both experiential and cognitive. I recognize that I am a participant in a process.

I understand that Rolfing is not involved with the treatment of disease and is not a substitute for medical diagnosis or treatment when such attention is needed. A Rolfer does not treat, prescribe or diagnose any illness, disease, or any other physical or mental disorder. Nothing said or done by a Rolfer should be misconstrued to be such.

I agree to pay in full for sessions missed or cancelled with less than 48 hours notice.

I have read and understand the above statements.

_____ _____

Signed Date

Please explain your goals for entering the Rolfing process. You may also use this question to examine your feelings and attitudes about your body.

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