Christopher Horan
Certified Rolfer™

Rolfing® Intake Form

Name (Print)_____Email:_____Phone:_____

Address:_____City:_____State:_____Zip:_____

Occupation:_____Date of Birth:_____

How were you referred to my office? (Referral/Yelp/Google/etc.)_____

Have you been Rolfed? Yes____No____How many sessions?_____By whom?_____

Are you under the care of a physician?_____For what condition?_____

Are you on any medication prescribed by a physician? Yes_____No_____What:_____

Do you use aspirin or other non-prescription drugs? Yes_____No_____What type/How often:_____

Are you involved in psychotherapy? Yes_____No_____

Are you involved in an exercise program? Yes_____No_____Describe:_____

Women: Are you pregnant? Yes_____No_____ Do you have an I.U.D.? 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____

Explain:_____

Continued on reverse side……..

Do you have any known issues of the feet, ankles, knees, hips or back? Yes_____No____Explain_____

Do you have any known digestive issues or concerns? Yes_____No____Describe_____

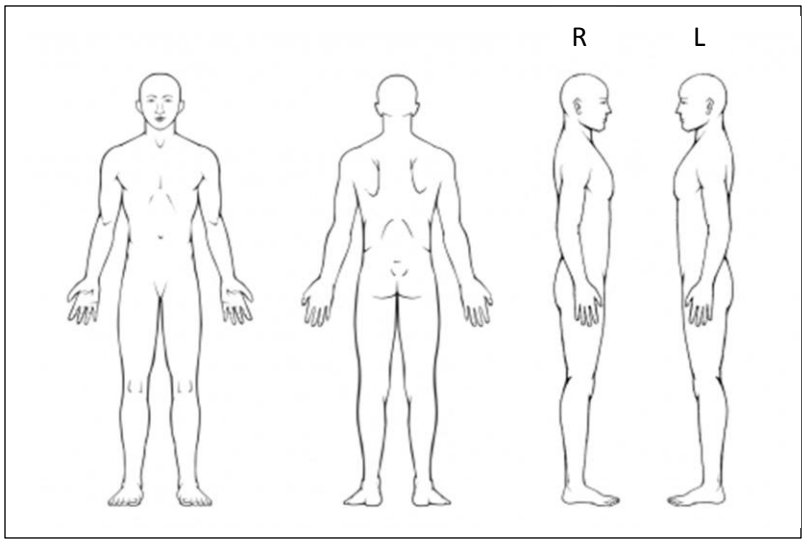
Please list *any* operations or injuries that you have had:_____

What is your primary reason for this office visit?_____

- How long ago did the issue start?_____Frequency:_____
- What relieves the symptom(s)?_____
- What exacerbates the symptom(s) (what makes it worse)?_____

Please list any secondary complaints and/or goals for receiving Rolfing?_____

Please circle on the diagram to the right where your primary source of pain in showing up. Please put a **"P"** next to primary and an **"S"** next to any secondary concerns.



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 establishing balance and alignment in my body.

I give **Christopher Horan** my permission and consent to do all the things necessary in helping me establish balance and alignment, including, but not limited to touching my body. I give the Rolfer full privilege 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 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 full responsibility for payment of the full fee.

SIGNED:_____DATE:_____

WITNESS:_____DATE:_____

(Parent or guardian of minor)