Michael Valenti, B.A., Certified Rolfer™ | 847-714-4078

Rolfing Intake and Consent Form

Name _____ DOB _____
Occupation _____
Address _____
Phone # _____ Work Phone # _____
Email _____
Referred by _____
Previous Rolfer _____

Are you currently in pain or discomfort?
_____
_____
_____

Please circle any of the following that you have or have experienced.

arthritis	skin disorders	broken bones
HIV/AIDS	joint pain	autoimmune disorder
osteoporosis	infections	radiating pain
headaches	numbness or tingling	TMJ issues
heart condition	respiratory issues	high blood pressure
hemophilia	cancer	cysts or tumors
whiplash	severe sprains	dizziness
contact lenses	concussions	pregnancies
_____	_____	_____

Please describe any injuries, accidents and surgeries that you may have had.
_____
_____
_____
_____
_____

Please list any medication that you are on.
_____
_____
_____
_____

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Agreements for Rolfing

I understand that the purpose of Rolfing is to balance and align my body so that it is supported by gravity and moves with greater ease and freedom. These goals are accomplished through manipulation and education–both experiential and cognitive.

I recognize that I am a participant in a process, and that my awareness and internal experience are a necessary part of the process. I agree to participate in this process as fully as I am able.

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 understand that sessions missed or cancelled with less than 24 hours notice will be charged for time lost.

I have read and understand the above statements.

Signed _____ Date _____

Please explain your reasons and your goals for entering the Rolfing process. You may use this question, if you wish, to examine your feelings and attitudes about your body.

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