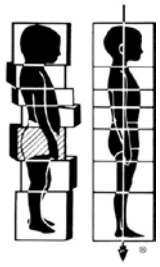
Mike Williams
Certified Rolfer™
8705 Shoal Creek Blvd., Suite 116
Austin, TX 78757
(512) 470-8998
mike@rolfaustin.com



Rolfing® Structural Integration Consent and Intake Form

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 and freedom of body-movement are 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 in establishing balance and alignment in the body. I give **Mike Williams, Certified Rolfer** my permission and consent to do all those 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 total human being and is not the basic goal of Rolfing.

Cancellation Policy: I understand that a minimum of 24-hours notice is required for cancellations. I agree to pay in full for any sessions canceled with less than 24-hours notice or for "no-show" appointments.

Name _____ DOB _____ Male ☐ Female ☐

Address _____

City _____ State _____ Zip _____ Phone _____

E-mail _____ Occupation _____

Emergency Contact _____

Phone _____ Relationship _____

Signature _____ Date _____

Signature of Parent/Guardian (if under 18 yrs of age) _____ Date _____

Client Intake Form

Sharing information is voluntary and is designed to improve the quality of our service to you. This information is strictly confidential and may be important to your therapy. Feel free to use the reverse as needed.

Name _____ Date _____

1. What are your 3 biggest health challenges currently?
   1)
   2)
   3)

2. How do those limit you?

3. What would you like to gain from this Rolfing experience?

4. What are your current daily activities (work, exercise, disciplines)?

5. Please circle if you have/have had any of these conditions and briefly describe (dates, etc.):

Spine/Scoliosis/Disc Issues	Jaw/TMJ Issues
Thrombosis	Rheumatism
Gastro-Intestinal Disturbances	Osteoporosis
Cardiopathy	Arthritis
Aneurism	Fibromyalgia
Migraines/Headaches	Chemical Dependency
Allergies	High/Low Blood Pressure
Anxiety	Stroke
Panic Attacks	Vertigo
Depression	Diabetes
Epilepsy	Cancer
Autoimmune Disease	Skin Conditions
Numbness/Tingling	Inflammation

6. Do you have any other condition that may deserve attention?

7. Have you ever had any accidents or falls? Yes ☐ No ☐
   If yes, when? Did they cause injury? If so, what kind? How was the injury treated?

8. Have you ever had surgery? Yes ☐ No ☐
   For what condition? When?

9. Are you currently receiving any kind of healthcare treatment? Yes ☐ No ☐
   Please specify (specify whether conventional medical or alternative/complementary treatment):

10. Previous bodywork experience: Never ☐ Occasionally ☐ Often ☐
    Types:

11. How did you learn about Rolfing/me (please specify)?

12. Is there anything else that feels significant to you that you want me to be aware of?

Females Only (Questions 13 and 14)

13. Are you pregnant or trying to become pregnant? Yes ☐ No ☐
    Due Date:

14. Do you have any children? Yes ☐ No ☐
    If yes, how many?

I certify that the above information is true and accurate to the best of my knowledge.

Signature _____ Date _____

Signature of Parent/Guardian (if under 18 yrs of age) _____ Date _____