

Mike Williams, Certified Rolfer™
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Informed Consent and Intake Form

Mike Williams is a Certified Rolfer and an advanced student of Hakomi Mindful Somatic Psychology. I am contracting with Mike Williams to receive Rolwing® Structural Integration, Hakomi, movement education, or a combination thereof. Mike uses several tools to aid in treatment, including direct manipulation, movement, visualization, and mindful awareness. At-home practices may be an important component of client learning and development.

The purpose of Rolwing is to balance and align the physical body so that it is supported and maintained by gravity in three-dimensional space. The Hakomi Method assists clients in becoming aware of how thoughts, emotions, physical sensations, memory, movement, and behavior are interconnected and can impact the physical body. The primary goals of our work using these methods are to create greater economy and freedom of body-movement, to build awareness of the ways the body and mind currently operate in the world, and to facilitate discovering and learning new adaptive skills.

I understand that this work is not involved with the treatment of disease of any kind, nor does it substitute for medical or mental health diagnosis or treatment when such attention is needed. Mike Williams does not treat, prescribe, or diagnose illness, disease, or any other physical or mental disorder of the person. Nothing said or done by Mike Williams should be misconstrued as such.

I understand it is necessary for a Rolfer to use touch as a clinical intervention in order to assist me in establishing balance and alignment in the body. I give Mike Williams full privilege and license to work on my body in such a way as to restore and establish balance and alignment therein. I also understand that touch may be used to aid the Hakomi process, and I give Mike Williams my permission to use touch as a clinical intervention as necessary and agreed upon during the course of treatment.

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.

By initialing here I acknowledge and agree to the 24-hour cancellation policy: _____

Name _____ DOB _____ Male Female

Address _____

City _____ State _____ Zip _____ Phone _____

E-mail _____ Occupation _____

Emergency Contact _____

Phone _____ Relationship _____

I have read and agree to the informed consent language above:

Signature _____ Date _____

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

7. To what do you attribute the results you've experienced to date?

8. If our work together were 100% successful, how would your life be different?

Big Picture Stuff

9. Take a look at your life from a whole-person perspective and evaluate which parts are in-balance and which parts may be out-of-balance. Mark those numbers below.

Physical Activity	Out of Balance	1	2	3	4	5	In Balance
Physical Health	Out of Balance	1	2	3	4	5	In Balance
Mental Health	Out of Balance	1	2	3	4	5	In Balance
Self-Care	Out of Balance	1	2	3	4	5	In Balance
Work-Life Balance	Out of Balance	1	2	3	4	5	In Balance
Relationships	Out of Balance	1	2	3	4	5	In Balance
Self-Awareness	Out of Balance	1	2	3	4	5	In Balance
Reflective Practices (spirituality, meditation, etc.)	Out of Balance	1	2	3	4	5	In Balance
Hobbies	Out of Balance	1	2	3	4	5	In Balance
Family	Out of Balance	1	2	3	4	5	In Balance

10. Evaluate how you rated yourself above and discuss any observations or conclusions drawn.

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

12. What do you do to take care of yourself (self-care, hobbies, etc.)? How do you tend to deplete yourself?

Health History

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

Spine/Scoliosis/Disc Issues
Jaw/TMJ Issues
Rheumatism/Joint Issues
Heart Condition
Aneurism
Thrombosis
High/Low Blood Pressure
Autoimmune Disease
Inflammation
Numbness/Tingling
Skin Conditions
Cigarette Smoker
Anxiety/Panic Attacks
Stress/Easily Stressed

Migraines/Headaches
Arthritis
Osteoporosis
Fibromyalgia
Stroke
Cancer
Diabetes
Epilepsy
Loss of Balance
Lack of Coordination
Allergies
Chemical Dependency
Depression
Abuse Survivor

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

15. 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?

16. Have you ever had surgery? Yes No

For what condition? When?

17. Are you currently receiving any kind of healthcare treatment? Yes No

Please specify (specify whether conventional medical or alternative/complementary treatment):

18. Previous bodywork experience: Never Occasionally Often

Types:

19. Are you currently in psychotherapy? Yes No

Since when?

Females Only (Questions 20 and 21)

20. Are you pregnant or trying to become pregnant? Yes No
Due Date: _____

21. Do you have any children? Yes No
If yes, how many and what age?

22. How did you find me (please specify)?

Yelp
Google
Google Map Search
Facebook

Rolf.org
Yahoo
Bing
Other _____

Keyword Search _____

Referral _____

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

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 _____