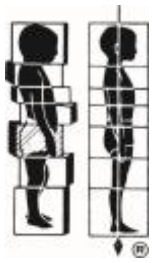
Rolfing PA
Intake Form



Name	Address	
Phone		
Cell	City	
Email	State	Zip
Preferred Communications ____ Email ____Phone ____ Text	Date of Birth	

Goals:_____

_____

Please check all that apply:

- ❑ Recent surgeries
- ❑ Recent injuries
- ❑ Current pain
- ❑ Pregnant
- ❑ Contagious conditions
- ❑ Open cuts or sores
- ❑ Serious disease
- ❑ High stress
- ❑ Taking medications
- ❑ Tried other modalities

How did you find out about Rolfing PA? _____

I understand that these sessions are not intended as substitution for medical examination, diagnosis, or treatment. Any consequences resulting from obtained services are my sole responsibility. I understand that the Rolfer may use, by mutual consent with me, an Erchonia Low Level Laser, cleared by FDA for safe and effective use on joint pain and stiffness, and that the use of this tool is currently beyond the generally accepted definition of "hands-only" Rolfing.

Signature_____ Date _____