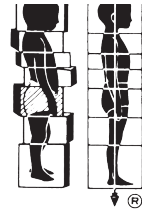


**Island Rolfing**  
**Brett Holland ♦ Certified Rolfer™**



**Client Intake Form**

Name: \_\_\_\_\_ Ph: (H) \_\_\_\_\_  
 Email: \_\_\_\_\_ Ph: (W) \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Ph: (C) \_\_\_\_\_  
 Other Contact: \_\_\_\_\_ Ph: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Province: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

*Do you have or have you ever had any of the following conditions / illnesses / problems?  
 Circle "Y" for yes or "N" for no.*

Aneurism.....	Y / N	Heart condition.....	Y / N
Arthritis.....	Y / N	Hemophilia.....	Y / N
Autoimmune disease.....	Y / N	High/Low blood pressure.....	Y / N
Cancer.....	Y / N	Osteomyelitis.....	Y / N
Contagious disorders.....	Y / N	Osteoporosis.....	Y / N
Convulsions.....	Y / N	Pain, numbness and/or tingling...	Y / N
Circulatory problems.....	Y / N	Phlebitis.....	Y / N
Chronic bodily discomfort.....	Y / N	Respiratory problems.....	Y / N
Diabetes.....	Y / N	Scoliosis.....	Y / N
Digestive problems.....	Y / N	Thyroid problems.....	Y / N
Eye,ear,nose,throat disorder.....	Y / N	Currently pregnant.....	Y / N
Fibromyalgia.....	Y / N	Other.....	Y / N

*Please list any past injuries, accidents, surgeries and/or serious illnesses.*

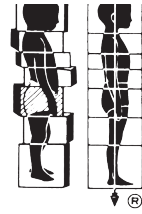
Dates:	Area(s) Affected:	Treatment(s):

Are you receiving care from other health care providers? .....Y / N  
 Does s/he approve of you being Rolfed? .....Y / N  
 What kind of provider(s)? (MD, LMT, ND, LAc, etc.) \_\_\_\_\_  
 What medications have you taken in the past 6 months? \_\_\_\_\_  
 What is your previous bodywork experience? \_\_\_\_\_  
 What physical activities do you do? \_\_\_\_\_  
 Is there anything else that feels significant to mention? \_\_\_\_\_  
 How did you find me? \_\_\_\_\_  
 Why do you want to receive Rolfing and what are your expectations for the work? \_\_\_\_\_

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

**Date:** \_\_\_\_\_ **Applicant's Signature:** \_\_\_\_\_

**Island Rolfing**  
**Brett Holland ♦ Certified Rolfer™**



**Client Consent Form**

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I hereby apply to receive Rolfing (structural integration).

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. However, I understand that the Rolfing Practitioner makes no warranties or guarantees regarding the results of the Rolfing process.

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 **Brett Holland, 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**

Cancellations must be made 24 hours prior to the scheduled appointment time to avoid the cancellation fee of \$50 (Cancellation fees are used to provide free work to the community).

**Date:** \_\_\_\_\_ **Applicant's Signature:** \_\_\_\_\_