# Denver Highlands & Wheatridge Rolfing®

**Stacie Scarbery, Certified Rolfer**
**3535 W44th Avenue**
**Denver, CO 80211**
**303.909.7706**

Name:__________________________ Date:____________________

Address:________________________ Weight:__________________

Phone:__________________________ Height:__________________

Email:__________________________ D.O.B:__________________

*Do you have or have you ever had any of the following conditions/illnesses/problems? Please circle all that apply. Be descriptive when appropriate.*

- Heart Condition
- Phlebitis
- High/Low Blood Pressure
- Respiratory Problems
- Hemophilia
- Eliminatory Problems
- Diabetes
- Circulatory Problems
- Cancer
- Digestive Problems
-

Contact Lenses

- Thyroid Problems
- Dentures/Removable Bridge
- Osteoporosis
- Convulsions
- Arthritis
- I.U.D.
- Osteomyelitis
- Other:______________________

______________________________

______________________________

Have you ever been or are you presently under the care of a medical physician/ chiropractor/therapist? If yes, for what?

_____________________________________________________________________________

If not, date of last physical___________________

What medication have you taken in the past 6 months?

_____________________________________________________________________________

Please describe any past injuries, accidents, surgeries, and pregnancies.

*Date/Year* _ *Area(s) Affected* *Treatment(s)*

_____________________________________________________________________________

_____________________________________________________________________________

Are you presently suffering from any areas of chronic or acute bodily discomfort?

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

What is your current diet?

What is your previous bodywork/massage experience, including how frequent?

Have you ever had a Rolfing® session before?  If so, When, and how many sessions?

What would you like to gain from Rolfing®?

Please include any other information that you feel may be useful:

*I fully understand the purpose of Rolfing is to balance and align the physical body so that it is supported and maintained by gravity. This is done through direct manipulation and education so that greater economy of body-movement is 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 any illness, disease, or 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 my body.*

*Furthermore, I certify that the information provided herein is true and accurate to the best of my knowledge.*

Signature

Date

______________________________ ____________________

Witness (Parent/guardian of minor) Date