Rolfing® SI Health Intake Form

Name _____ Preferred Phone # _____
Address: _____
Email: _____ Occupation _____
Birthdate _____ Height _____ Weight _____
Hobbies _____

Do you have or ever had any of the following conditions, illnesses or problems?

_____ Heart condition	_____ High blood pressure	_____ Hemophilia	_____ Diabetes
_____ Respiratory problems	_____ Low blood pressure	_____ Convulsions	_____ Cancer
_____ Circulatory problems	_____ Digestive problems	_____ Other: _____	

Please describe any of the above, including approximate dates of illness and treatment: _____

_____

Are you currently under the care of a medical physician, chiropractor or other therapist? _____

If yes, please describe: _____

If not, please indicate approximate date of last physical: _____

What medication(s) have you taken during the last six months? _____

_____

Please describe, including approximate dates, sites of injuries and treatments:

Past injuries _____

Past accidents _____

Past surgeries _____

Previous bodywork _____

What would you like to gain from Rolfing Structural Integration? _____

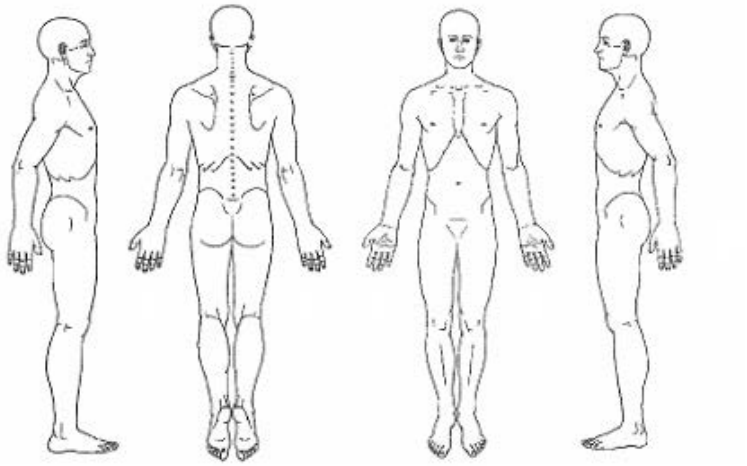
_____

Where did you learn about Rolfing SI? _____

Questions prior to beginning: _____

Please feel free to ask questions at any time during the process. Client communication is vital to the work.

Please note any areas of discomfort, pain, or concern on the diagram below.



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

Date: _____ Applicant's Signature: _____