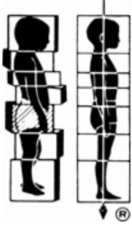

Rolfing® Structural Integration Health Intake Form

Please print clearly.
Note: This form is used as a guideline for further discussion about your general health and well-being.

Name ______________________________ Age _______ Weight _______ Height _______

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.

Thank you for taking the time to fill out this questionnaire. It will remain confidential.
We appreciate your continued participation in your own good health.