# Rolfology Rolfing® Structural Integration Health Intake Form

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

Name _____ Date _____

Age _____ Weight _____ Height _____

State your occupation and/or daily activities. _____

Do you have, or have you 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 sites of injuries and types of treatments, including approximate dates.

Injuries _____

Accidents _____

Surgeries _____

Bodywork _____

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

_____

Where did you learn about Rolfing® SI? _____

Do you have any questions prior to beginning? _____

_____

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

Thank you for taking the time to fill out this questionnaire. The information provided will remain confidential. We appreciate the opportunity to contribute to your journey of participation in your health.

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503-966-8433 • info@rolfology.com

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