



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.**