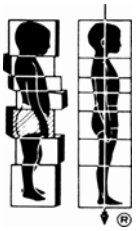

Rolfing® Structural Integration Health Intake Form

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.