Rolfing® Structural Integration Client Intake Form

Sharing information is voluntary and is designed to improve the quality of service to you. This information is strictly confidential and may be important to your therapy. Feel free to use the reverse as needed.

Name ____ DOB ____________ Male ☐ Female ☐

Address ____

City _______________________ State ______ Zip ____________ Height _________ Weight _________

Phone (h)_______________________(w)________________________(c)_______________________

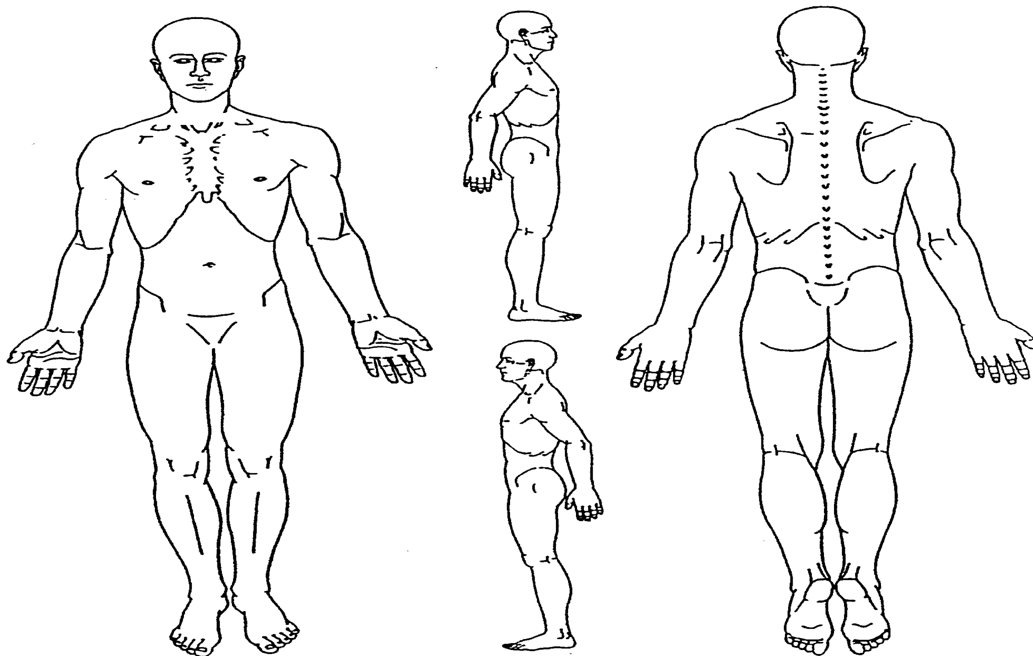
Email _____________________________________ Occupation ______________________________

Preferred Method(s) of Contact ____

Emergency Contact ____

Phone __________________________ Relationship ______________________________________

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



1. What are your 3 biggest health challenges currently?

    1)

    2)

    3)

2. How do those limit you?

3. What would you like to gain from this Rolfing experience?

4. What are your current daily activities (work, exercise, hobbies, etc.)?

5. Please circle if you have/had any of these conditions and briefly describe (dates, etc.):

Allergies
Aneurism
Anxiety
Arthritis
Autoimmune Disease
Cancer
Chemical Dependency
Communicable Disease
Depression
Diabetes
Epilepsy
Fibromyalgia
Gastro-Intestinal Disturbances
High/Low Blood Pressure
Heart Disease/Condition
Inflammation
Jaw/TMJ Issues
Migraines/Headaches
Numbness/Tingling
Osteoporosis
Panic Attacks
Rheumatism
Seizures/Convulsions
Skin Conditions
Spine/Sciolosis/Disc Issues
Stroke
Thrombosis
Vertigo

6. Do you have any other condition(s) that may deserve attention?

7. Have you ever had any accidents or falls? Yes ☐ No ☐
   If yes, when? Did they cause injury? If so, what kind? How was the injury treated?

8. Have you had any other major injuries? Yes ☐ No ☐
   If yes, when? What kind? How was the injury treated?

9. Have you ever had surgery? Yes ☐ No ☐
For what condition? When?

10. Are you currently receiving any kind of healthcare treatment? Yes ☐ No ☐
Please specify (specify whether conventional medical or alternative/complementary treatment):

11. Previous bodywork experience: Never ☐ Occasionally ☐ Often ☐
Types:

12. How did you learn about Rolfing/me (please specify)?

13. Is there anything else that feels significant to you that you want me to be aware of?

Females Only (Questions 14 and 15)

---

14. Are you pregnant or trying to become pregnant? Yes ☐ No ☐
Due Date:

15. Do you have any children? Yes ☐ No ☐
If yes, how many?

I certify that the above information is true and accurate to the best of my knowledge. I understand that it is my responsibility to inform the practitioner of any changes to this information.

Signature ____ Date ____________

Signature of Parent/Guardian (if under 18 yrs of age) ____________________ Date ____________