



Allison Benner, Certified Rolfer™

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PLEASE PRINT CLEARLY. This is used as a guideline. There will be further discussion with your Rolfer.

Name: _____ Date: _____
 Address: _____ Weight and Height: _____
 _____ Emergency contact and phone #: _____
 Phones: (h) _____ Birth date: _____
 (c) _____ Sex: M F
 (w) _____ Email: _____

Do you have or have you ever had any of the following conditions, illnesses, or problems?

Check YES (Y) or NO (N).

Any History of:	Y	N		Y	N
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Orthopedic Braces (for legs)	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Mental/ Nervous Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Eliminatory Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Circulatory Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Dentures, Removable Bridge	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Orthodonture (Braces)	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Contagious or communicable disorders	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Breast Augmentation/ Reduction	<input type="checkbox"/>	<input type="checkbox"/>	Whiplash	<input type="checkbox"/>	<input type="checkbox"/>

Please elaborate on any yes answers to the history above. _____

1. Are you currently under the care of a physician/ chiropractor/ therapist?
If YES, for what? _____

If NO, date of last physical: _____

2. What Medications have you taken in the last 6 months? _____

3. Do you have any areas of chronic bodily discomfort? _____

4. What is your current exercise program? _____

5. Do you feel tired very often? _____

6. Women - Are you pregnant? _____ How many weeks? _____ Do you have an IUD? _____

7. What is your previous bodywork experience, including how frequent? _____

8. Have you ever been Rolfed before, if so how many sessions? _____

9. What would you like to gain from the experience of being Rolfed? _____

10. How did you learn about Rolfing? _____

Please describe any past accidents, injuries, or surgeries.

Dates	Areas Affected	Treatments