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

Name: ______________________________ Date: ______________________________

Email: ______________________________ Date of Birth: ______________________

Phones: (h)___________________________ Address: ______________________________

(c)___________________________ ______________________________

(w)___________________________ Emergency contact and phone #: ______________________

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
Heart Condition	☐	☐
High/Low Blood Pressure	☐	☐
Hemophilia	☐	☐
Diabetes	☐	☐
Cancer	☐	☐
Thyroid problems	☐	☐
Birth Defects	☐	☐
Dentures, Removable Bridge	☐	☐
Orthodonture (Braces)	☐	☐
Contact Lenses	☐	☐
Contagious or communicable disorders	☐	☐
Breast Augmentation/ Reduction	☐	☐

	Y	N
Arthritis/ Osteoporosis	☐	☐
Orthopedic Braces (for legs)	☐	☐
Mental/ Nervous Disorder	☐	☐
Respiratory Disorder	☐	☐
Eliminatory Disorder	☐	☐
Circulatory Disorder	☐	☐
Digestive Disorder	☐	☐
Chronic Fatigue	☐	☐
Epilepsy	☐	☐
Phlebitis	☐	☐
Asthma	☐	☐
Whiplash	☐	☐

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

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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 are your primary goals for treatment?

5. What is your current exercise program? What physical activities are enjoyable? Do you feel limited in any activities?

6. Do you feel tired very often?

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

8. What is your previous bodywork experience, including how frequent

9. Please describe any past accidents, injuries, or surgeries.

Dates	Areas Affected	Treatments

10. How did you learn about Rolfing?