ROLFING: Client Intake Form

Name: _____ Date of Birth: _____

Address: _____ Date of first visit: _____

_____ Referred by: _____

Phone: _____ Email: _____

General & health-related Information:

Height: _____ Weight_____

Do you exercise or participate in Sports? Which ones?

_____

_____

_____

Have you recently suffered an acute injury or have areas of inflammation? _____

_____

_____

History of accidents: _____

_____

_____

_____

Have you had any surgery? If yes, explain:

_____

_____

_____

Any medical condition I should know about?

_____

_____

_____

Do you take any medications? Which ones?

_____

_____

_____

Are you pregnant?___ Are you wearing an IUD? _____

Do you have a known Leg Length discrepancy?

Which leg is longer? _____

How many inches? _____

Health history:

	Yes	No
Contact Lenses	☐	☐
Dentures	☐	☐
Back Pain/ Sciatica	☐	☐
Spinal Problems	☐	☐
Osteoporosis/ Broken Bones	☐	☐
Easy Bruising	☐	☐
Skin Problems	☐	☐
Headaches/Migraines	☐	☐
TMJ Syndrome	☐	☐
Allergies/ Asthma	☐	☐
Varicose Veins	☐	☐
Phlebitis/Blood Clots	☐	☐
Heart Problems	☐	☐
High/low Blood Pressure	☐	☐
Ulcer	☐	☐
Tendonitis, Bursitis, etc.	☐	☐
Arthritis	☐	☐
Diabetes	☐	☐
Seizure, Convulsions	☐	☐
Multiple Sclerosis	☐	☐
Cancer or Tumors	☐	☐
Venereal Disease/ Herpes	☐	☐
Infections/Communicable Diseases	☐	☐

Rolfing Goals:

If you could change/improve 5 things in regard to your body, what would they be? Please prioritize:

1. _____

2. _____

3. _____

4. _____

5. _____