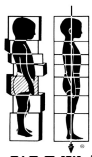

Rolfing® Structural Integration Intake Form

Please print clearly

Name: _____ Birth Date: _____

Mail Address: _____ Height: _____

_____ Weight: _____

Phone: (H) _____ (W) _____ (C) _____

Email: _____ Occupation: _____

Do you have or have you ever had any of the following conditions / illnesses / problems? Circle "Y" for yes or "N" for no.

Heart Condition	Y	N	High/Low BP	Y	N
Digestive Problems	Y	N	Eye, ear, nose, throat disorder	Y	N
Hemophilia	Y	N	Diabetes	Y	N
Contagious or communicable disorders	Y	N	Disability of feet, ankles, knees, hips, or back	Y	N
Cancer	Y	N	Convulsions	Y	N
Pain, numbness and/or tingling in limbs	Y	N	Chronic bodily discomfort	Y	N
Thyroid Problems	Y	N	Osteoporosis	Y	N
Chest pain during exertion	Y	N	Excessive tiredness	Y	N
Arthritis	Y	N	Osteomyelitis	Y	N
Illness or injury at the present time	Y	N	Contact Lenses	Y	N
Phlebitis	Y	N	Respiratory Problems	Y	N
Dentures / Removable Bridge / Braces	Y	N	Circulatory Problems	Y	N
Eliminatory Problems	Y	N	Currently pregnant	Y	N
I.U.D	Y	N	Other:		

Please elaborate on any Yes answers:

Please list any past injuries, accidents, surgeries and/or serious illnesses.

Dates:	Area(s) Affected:	Treatment(s):

Are you currently under the care of a physician / chiropractor / therapist? Y / N If yes, for what? _____

Does she/he approve of you undergoing Structural Integration? Y / N Date of last physical: _____

What medications have you taken in the past 6 months? _____

What is you current exercise program and diet? Caffeine? Y / N Smoke? Y / N _____

_____

How did you find out about Structural Integration and about me as a practitioner? _____

What is your previous bodywork (physiotherapy, chiropractic, massage, Body Stress Release, etc.) experience?

_____

Why do you want to receive Structural Integration and what are your expectations for the work? _____

_____

_____

I certify that the above information is true and accurate to the best of my knowledge.

_____ _____

Signature Date