

CONFIDENTIAL PERSONAL INFORMATION

Full Legal Name: _____/_____/_____

Preferred Name: _____ Age: _____ Date of Birth: _____

Address: _____/_____/_____/_____
(street#/PO Box) (city) (state) (Zip code)

Telephone # (____) _____ (cell) (____) _____`

E-mail address: _____

Gender: female _____ male _____

Occupation: _____

Emergency Contact and phone number _____

What is the best way to communicate with you between office visits? (E-mail, Home or cell phone).

Is there any place you do NOT want me to leave a message? _____

Please circle any conditions that are applicable to you:

1. Heart Condition
2. High/Low Blood Pressure
3. Hemophilia
4. Diabetes
5. Cancer
6. Convulsions
7. Osteoporosis
8. Arthritis
9. Phlebitis
10. Respiratory Problems

11. Circulatory Problems
12. Digestive Problems
13. Removable Bridge
14. Orthodonture (Braces)
15. Extremity Numbness
16. Headaches
17. Dizziness
18. Back Pain
19. Herniated Disc

Are you currently under medical care? Y N

If YES, for what?

Please list any current or recent injuries.

Do you have any areas of chronic bodily discomfort?

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What kinds of exercise do you do?

What is your previous experience with bodywork/massage?

Have you received Rolfing Structural Integration before? If so how many sessions?

What would you like to gain from you experience of receiving Structural Integration?

Please mark or circle any areas of discomfort.

