RYAN'S ROLFING

HEART CENTERED HEALING

HEALTH INTAKE FORM

Please complete the following form carefully. Use the back of the form if you need extra space and indicate that you are doing so on the front of the form.

Name:		
Address:		Zip:
Home Phone:	Work Phone:	Cell Phone:
Occupation:	Birth Date:	

Why do you want to be Rolfed?

What are your goals/expectations for your Rolfing session(s)?

Do you have any chronic complaints?
(Things that you may or may not have given up on, or accepted i.e., headaches, constipation, etc.)

Are you, or have you, participated in "self-improvement" or "self awareness" programs?
(i.e., psychic, spiritual, yoga, meditation etc.)

PHYSICAL ACTIVITIES

Type of Activity	Duration	Times per Week

How do you relax?

CHECK MARK YES OR NO NEXT TO THE FOLLOWING QUESTIONS.

	YES	NO
Do you have heart or artery disease?	☐	☐
Do you have a mental or nervous disorder?	☐	☐
Do you have diabetes?	☐	☐
Do you have a genito-urinary disorder?	☐	☐
Do you have epilepsy?	☐	☐
Do you have cancer or malignancy?	☐	☐
Do you have a birth defect?	☐	☐
Do you have high blood pressure?	☐	☐
Do you have an ulcer or digestive disorder?	☐	☐
Do you have a respiratory disorder?	☐	☐
Do you have an eye, ear, nose or throat disorder?	☐	☐
Is your heart beat ever irregular, or do you have spells where it is suddenly fast?	☐	☐
Do you have chest pains during vigorous exertion?	☐	☐
Do you have gout, arthritis or rheumatism?	☐	☐
Are you on any medication prescribed by a physician?	☐	☐
If you are under the care of a physician, does he/she approve of you being Rolfed?	☐	☐
Are you seeing a psychiatrist or psychotherapist?	☐	☐

Do you have any illness at the present time? If "Yes", please describe:	
Please list any operations/serious illness/accidents you have had in your life:	
Your present weight:	Height:
Do you feel tired very often?	What is your resting pulse?
Do you drink alcohol?	How may drinks per day?
Do you use aspirin or any other non-prescription drug?	
What type?	How often?

Please check any symptoms that apply to you and indicate right or left when applicable:

HEAD	YES	NO
Temples	☐	☐
Entire head	☐	☐
Light headedness	☐	☐
In the eyes	☐	☐
Forehead	☐	☐
Base of Skull	☐	☐
Pain in ears	☐	☐
Fainting	☐	☐
Top of head	☐	☐
Dizziness	☐	☐
Ringing in ears	☐	☐
Other:		

NECK	YES	NO
Stiffness	☐	☐
Diagnosed disc herniation	☐	☐
Grating sound with neck movement	☐	☐
Pain at neck shoulder junction	☐	☐
Muscle spasm in neck	☐	☐
Diagnosed bone spurs	☐	☐
Pain when turning head	☐	☐
Pain with side to side movements	☐	☐
Neck feels out of place	☐	☐

SHOULDER	YES	NO
Pain in shoulder	☐	☐
Pain deep in shoulder joint	☐	☐
Can't raise arm above shoulder level	☐	☐
Can't raise arm over head	☐	☐
Diagnosed bursitis	☐	☐
Front	☐	☐
Diagnosed Arthritis	☐	☐
Back	☐	☐
Side	☐	☐

ARMS AND HANDS

	YES	NO
Pain in upper arm	☐	☐
Sensation of pins & needles in arm	☐	☐
Sensation of pins & needles in fingers	☐	☐
Swollen joints in finger	☐	☐
Pain in forearm	☐	☐
Sore joints in fingers	☐	☐
Fingers go to sleep	☐	☐
Pain with side to side movements	☐	☐
Pain in wrist	☐	☐
Diagnosed arthritis	☐	☐
Pain in fingers	☐	☐
Hands cold	☐	☐
Loss of grip strength	☐	☐

MID-BACK

	YES	NO
Mid-back pain	☐	☐
Pain with breathing	☐	☐
Pain between shoulder blades	☐	☐
Pain across mid back	☐	☐
Other:		

LOW BACK

	YES	NO
Low back pain	☐	☐
Low back pain is worse when standing	☐	☐
Pinched nerve in low back	☐	☐
Diagnosed disc herniation	☐	☐
Low back pain is worse when lifting	☐	☐
Low back pain is worse when bending	☐	☐
Pain up/down low back	☐	☐
Low back pain is worse when working	☐	☐
Low back pain is worse when sitting	☐	☐
Low back feels out of place	☐	☐
Low back pain is worse when stooping	☐	☐
Low back pain is worse when coughing	☐	☐
Pain across low back	☐	☐

HIP	YES	NO
Pain in buttocks	☐	☐
Pain in buttocks when standing	☐	☐
Pain in buttocks when sitting	☐	☐
Pain in sit bone	☐	☐
Diagnosed bursitis	☐	☐
Pain deep in hip joint	☐	☐
Pain on side of hip	☐	☐
Diagnosed arthritis	☐	☐

LEGS AND FEET	YES	NO
Pain down leg	☐	☐
Pins and needles in leg	☐	☐
Numbness in foot	☐	☐
Cramps in foot	☐	☐
Swollen foot	☐	☐
Pain in knee	☐	☐
Pain down both legs	☐	☐
Numbness in toes	☐	☐
Swollen ankle	☐	☐
Diagnosed arthritis	☐	☐
Leg cramps	☐	☐
Numbness in leg	☐	☐
Cold feet	☐	☐
Other:	☐	☐

Additional comments and/or information or comments that you want me to know?

☐ I certify that the above stated information is true and accurate to the best of my knowledge at the present time.

SIGNED: _____ DATE: _____