Rachel Felson
Certified Rolfer®

Today's Date: ___-___-20___ How Did You Hear About Me? ___________________________
Name: _________________________________ Date of Birth: ___-___-_____ Sex: M F TG
Street Address: ___________________________ City: ________________State:___ Zip: _______
Email Address: _________________________@_____________________________
Home Phone #: ____-____-____ Work Phone #: ____-____-____ Cell Phone #: ____-____-____
Primary Medical Caregiver (MD/ND): ____
Emergency Contact: ____________ Phone #: ____-____-____ Relationship: ________________

Intent for Sessions:

• What is your primary reason for coming to Rolfing®?

____

• What, if any, other forms of medical treatment or complementary care have you pursued for this primary reason?

____ duration ____-____
____ duration ____- ____

• What do you most value about your body and its structure at present?

____

Body History:

What is your livelihood (lawyer, stay-at-home parent, car mechanic, etc.)? What does it require of your body (lifting, commuting, typing, sitting, etc.)? What physical impact do your hobbies (carpentry, knitting, cooking, etc.) have?

____
____
____

What is your relationship to movement or formal exercise? Do you practice any form of movement (walking, manual labor, qi gong, dancing, cycling, swimming, etc.) with regularity? If so, what form(s) and with what typical frequency?

____
____
____

What is your customary sleeping position?

____

Are you, or could you be, pregnant? YES or NO Have you ever given birth? YES or NO
If so, how many times? __ Was it a vaginal or cesarean birth(s)? _______________________________

Do you have any history of STDs? YES or NO If yes, which? _______________________________________

Are you currently pursuing, or have you ever pursued, any type of mental health treatment (including psychiatric medication, traditional or non-traditional therapy)? YES or NO If yes, which? _______________________________
Are there any related mental or emotional issues of which I should be aware? _______________________________
____

List all accidents, injuries, surgeries, and orthodontics to date and related care history (continue on back, as necessary).

Month/Year Physical Ailment Action Taken Result
__/_____ ____
__/_____ ____
__/_____ ____

What pharmaceutical medications, over-the counter drugs, and dietary supplements/vitamins do you take?

Drug/Supplement Name Your Purpose for Usage Frequency of Intake

____
____
____

Are there any other health conditions or history of which I should be aware? If yes, please explain.