LOUISVILLE ROLFING - HEALTH HISTORY INTAKE

Name _____ Date _____

Address _____ Date of Birth_____

City, State, Zip _____

Phone Number_____

Emergency Contact Name _____ Phone number _____

How did you learn about me?_____

Email_____
Would you like to receive my very occasional (1x per year) email newsletter? ____Yes ____No

This information will help me help you. It's important for me to know if there are any limitations in our work together. The rest helps me get to know you, and you are free to disclose as much or as little as you wish.

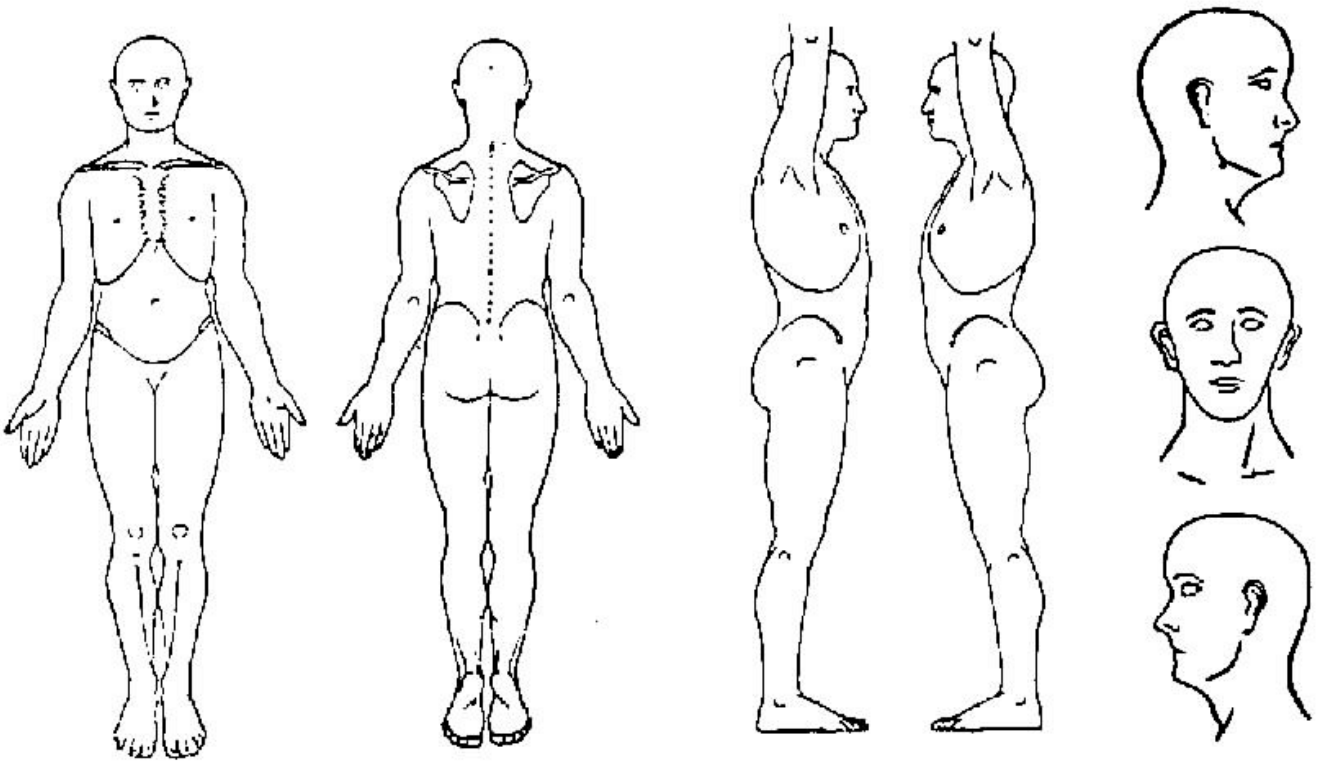
What are the main concerns you have for seeking help at this time? You can include your symptoms, pain, illness, injuries, onset, upsets, losses, functional problems, fears, worries, etc.

What would you like to achieve? What are your goals?

Past Medical History (include dates)
Include major illnesses, surgeries, hospitalizations, accidents, injuries, musculoskeletal problems and ongoing medical problems.

Please list other important body experiences: sports, hobbies, relationships, pregnancy and childbirth, sedentary or demanding work, traumatic experiences, successes and accomplishments, etc.

Please describe what you feel in your body and mark on the chart where you feel your symptoms.



List the medications, supplements, remedies and herbs you take.

Do you have any allergies? Yes___ No___ Please list:

Do you exercise? Yes____ No____ What do you do, how often, and how much?

What are the stressors in your life right now?

How do you reduce your stress? What do you enjoy doing?

How is your sleep?

Do you have any other past or present physical or psychological experiences I should know about?

Is there anything else you would like me to know?