

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. Please share as much as feels relevant to the work you want to do with me. I do need to know if there are any limitations or sensitivities I should be aware of in our work together. The rest helps me get to know you, but isn't required. You are free to disclose as much or as little about yourself 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.

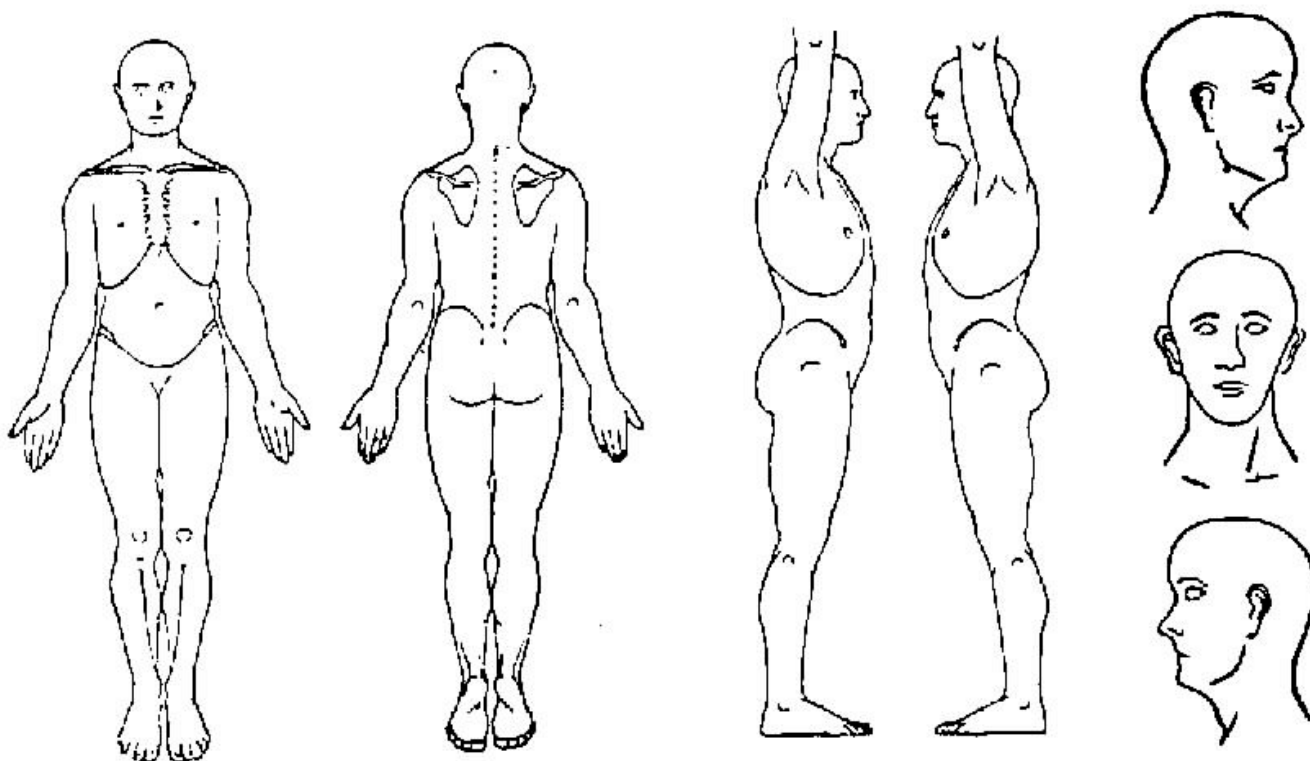
What would you like to achieve? What are your goals?

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?