CATHERINE TAYE SLATTERY - 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

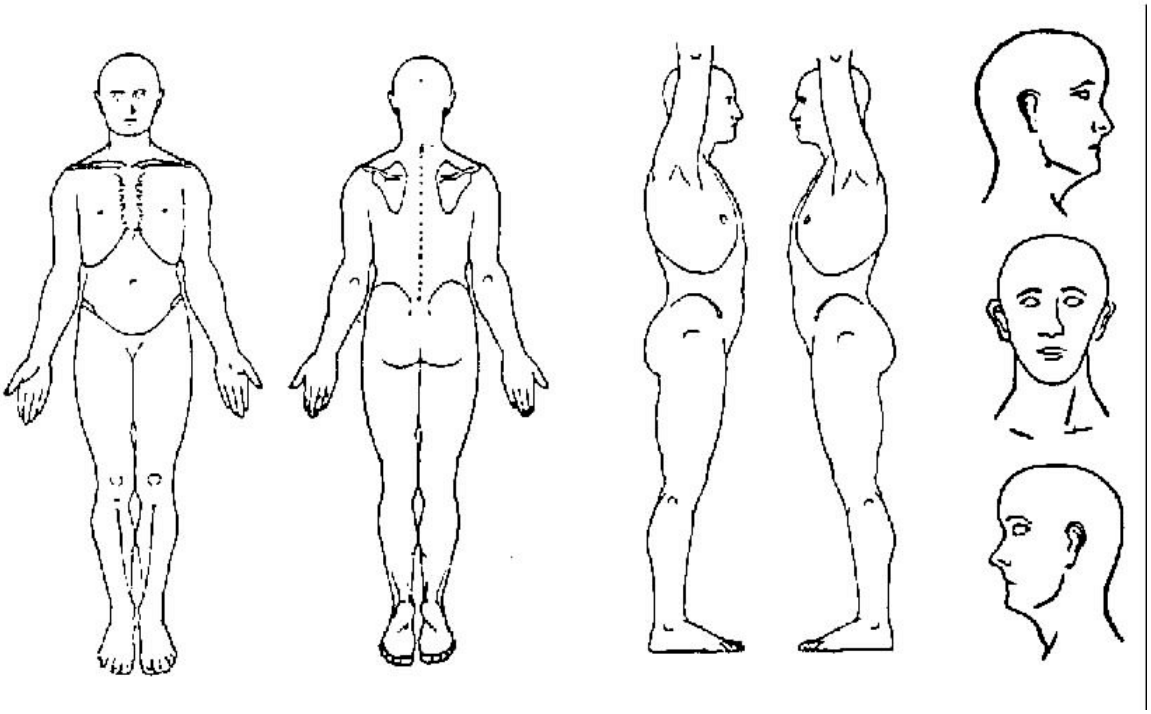
What are the main concerns you have for seeking help at this time? You can include your symptoms, pain, illness, injuries, onset, upsets, losses, functional problems, fears, worries, etc.

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

Past Medical History (include dates)

Include major illnesses, surgeries, hospitalizations, accidents, and injuries.

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



Have you been treated for musculoskeletal problems or ongoing medical problems?

Yes____ No____ Please Describe:

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 about?