JIRI PEREMSKY
Certified Rolfer
714-206-4518

ROLFING® Intake Form

Name (Print)____________________ Phone-Work ( )__________ Home ( )__________

Address____________________ City__________ State____ Zip____

Occupation____________________ Height____ Weight____

Date of Birth__________ How were you referred to Rolfing?__________

Have you been Rolfed? Yes __ No __ How many sessions? ____ By whom?__________

Are you under the care of a physician? ____ For what condition? ____ Does he/she approve of your being Rolfed? ____

Are you on any medication prescribed by a physician? Yes ___ No ___ What__________

Do you use aspirin or other non-prescription drugs? Yes ___ No ___

What type and how often?__________

Are you involved in psychotherapy? Yes ___ No ___

Are you involved in an exercise program? Yes ___ No ___ For how long?__________

Describe____________________

Have you ever worn braces? Yes ___ No ___ Do you wear contacts? Yes ___ No ___

Women: Are you pregnant? Yes ___ No ___

ANY HISTORY OF:

	Yes	No		Yes	No
Heart Condition	☐	☐	Cancer	☐	☐
High Blood Pressure	☐	☐	Diabetes	☐	☐
Arthritis	☐	☐	Respiratory Disorder	☐	☐
Osteoporosis	☐	☐	Asthma	☐	☐
Ulcer/Digestive Disorder	☐	☐	Epilepsy	☐	☐
Mental/Nervous Disorder	☐	☐	Phlebitis	☐	☐
Genito-Urinary Disorder	☐	☐	Birth Defects	☐	☐

Please elaborate on any **yes** answers to the history above ____________________

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____

Do you have radiating pain in any limbs? Yes ___ No ___ Numbness or tingling? Yes ___ No ___

Explain____________________

Form cont. on reverse side...