Rolfing & Somatic Solutions
mind-body healing

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Rolfing Solutions LLC d/b/a Rolfing & Somatic Solutions

PLEASE PRINT CLEARLY. This is used as a guideline. There will be further discussion with your practitioner.

Name: _____ Date: _____

Email: _____ Date of Birth: _____

Phones: (h)_____ Address: _____

(c)_____ _____

(w)_____ Emergency contact and phone #: _____

Do you have or have you ever had any of the following conditions, illnesses, or problems?
Check YES (Y) or NO (N).

| Any History of: | Y | N |
|---|---|---|
| Heart Condition | ☐ | ☐ |
| High/Low Blood Pressure | ☐ | ☐ |
| Hemophilia | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Thyroid problems | ☐ | ☐ |
| Birth Defects | ☐ | ☐ |
| Dentures, Removable Bridge | ☐ | ☐ |
| Orthodonture (Braces) | ☐ | ☐ |
| Contact Lenses | ☐ | ☐ |
| Contagious or communicable disorders | ☐ | ☐ |
| Breast Augmentation/ Reduction | ☐ | ☐ |

| | Y | N |
|---|---|---|
| Arthritis/ Osteoporosis | ☐ | ☐ |
| Orthopedic Braces (for legs) | ☐ | ☐ |
| Mental/ Nervous Disorder | ☐ | ☐ |
| Respiratory Disorder | ☐ | ☐ |
| Eliminatory Disorder | ☐ | ☐ |
| Circulatory Disorder | ☐ | ☐ |
| Digestive Disorder | ☐ | ☐ |
| Chronic Fatigue | ☐ | ☐ |
| Epilepsy | ☐ | ☐ |
| Phlebitis | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Whiplash | ☐ | ☐ |

Please elaborate on anything you answered yes to in the history above.

_____

_____

_____

_____

_____

1. Are you currently under the care of a physician/ chiropractor/ therapist?
If YES, for what?_____

_____

If NO, date of last physical:_____

2. What Medications and supplements have you taken in the last 6 months?_____

3. Do you have any areas of chronic bodily discomfort? _____

_____

4. What are your primary goals for treatment?

_____

_____

5. What is your current exercise program? What physical activities are enjoyable? Do you feel limited in any activities?____

_____

6. Do you feel tired very often? _____How is sleep for you?_____

_____

7. Women - Are you pregnant? _____How many weeks?_____Do you have an IUD?

8. What is your previous experience with bodywork/healing/therapy etc, including how frequent? _____

9. Please describe any past accidents, injuries, or surgeries.

| Dates | Areas Affected | Treatments |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

10. Please elaborate on any of the above list. _____

_____

_____

11. How did you learn about Rolfing/Craniosacral/YogaTherapy/SomaticExperiencing?

_____

_____