Winston Rolfing® Structural Integration

Experience your natural state of being

CLIENT INFORMATION

Name: _____ Referred by: _____

Address: _____ City/State: _____ ZIP: _____

Phone [Primary]: (___) _____ [Secondary]: (___) _____ Email: _____

Occupation: _____ Date of Birth: _____ ☐ Male ☐ Female

Physician Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

If you have ever received Rolfing Structural Integration, how recently? _____

Please check any of the following conditions that currently apply to you or have applied:

- ☐ Allergies
- ☐ Anxiety
- ☐ Arthritis
- ☐ Auto-Immune Disease
- ☐ Back pain
- ☐ Bruise easily
- ☐ Cancer
- ☐ Childbirth
- ☐ Circulation issues
- ☐ Chiropractic care
- ☐ Contact lenses
- ☐ Contagious disease
- ☐ Convulsions/seizures
- ☐ Cosmetic surgery
- ☐ Dentures
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive problems
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Headaches
- ☐ Heart condition
- ☐ Hernia
- ☐ High/low blood pressure
- ☐ IUD
- ☐ Joint issues
- ☐ Kidney/Urinary issues
- ☐ Orthopedic brace/shoes
- ☐ Osteoporosis
- ☐ Pain, chronic or acute
- ☐ Phlebitis/hemophilia
- ☐ Pregnant
- ☐ Respiratory disorders
- ☐ Scoliosis
- ☐ Sensitivity to touch
- ☐ Sinus problems
- ☐ Stress
- ☐ Surgical pins/plates
- ☐ Tension or soreness
- ☐ Thyroid problems
- ☐ TMJ Pain
- ☐ Ulcer
- ☐ Varicose veins
- ☐ Whiplash

Other:

- ☐
- ☐
- ☐

Please explain any car accidents or serious injuries you have sustained: _____

Please list the type and name of any medical, osteopathic or psychiatric doctors you are working with now: _____

Please explain any surgeries: _____

Please list any medications you have taken in the last 6 months: _____

Please list any bones you have broken or sprained: _____

Please list any joints you have dislocated or sprained: _____

What kinds of exercises do you do and how often? _____

Why do want to receive Rolfing? _____