



# North Star Integration

Discover physical enlightenment

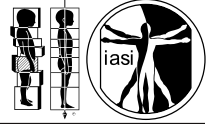
1727 NE 13th Ave., Ste. 101, Portland, OR 97212

503-933-8066

www.NorthStarIntegration.com

Jon Grossart, Certified Advanced Rolfer™

OR LMT #13752



## Client Intake Form *(Please print clearly)*

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: M or F  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Phone: (primary) \_\_\_\_\_ (other) \_\_\_\_\_ Email: \_\_\_\_\_

Please circle any current or major/chronic issues from the following conditions, illnesses, or problems: (and describe below)

- Musculoskeletal: torn muscle; sprains; arthritis; osteoporosis; osteomyelitis; joint replacment; joint noise/popping; TMJ; slipped/degenerative/bulging discs; broken bones; easily dislocated joints
- Cardiovascular: heart condition; high/low blood pressure; atherosclerosis; hemophilia; phlebitis, chest pain during exertion
- Nervous: pain, numbness, or tingling in your limbs; neuropathy; pinched nerve; sciatica; shooting, electrical sensations
- Respiratory: asthma; nose and throat problems; chronic sinus issues; chronic nose bleeds
- Digestive: acid reflux; ulcers; constipation; diarrhea; gall stones; pancreatitis
- Endocrine: thyroid; parathyroid; pituitary (hyperactive or hypoactive)
- Urinary/Reproductive: kidney stones; renal failure; UTI; IUD/IUC; currently pregnant, bladder control; loss of pelvic sensation
- Skin: rashes; psoriasis; shingles
- Other: Diabetes; Cancer; Convulsions; Headaches/Migraines; Knocked unconscious; Epilepsy; Excessive tiredness; Eye disorder; Lymphatic; surgery; accidents; injuries

Please describe any CURRENT medical conditions (including and beyond the list above) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list any PAST conditions (injuries, accidents, surgeries, etc.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have any contagious or communicable disorders? Y / N Describe \_\_\_\_\_

What medications have you taken in the past 6 months? \_\_\_\_\_

Are you currently under the care of other health care providers? Y / N Does s/he approve of you receiving Roling? Y / N / unknown

What kind of provider(s)? (MD, LMT, ND, LAc, etc.) \_\_\_\_\_ Date of last physical: \_\_\_\_\_

Have you ever worn braces, dentures, etc.? Y / N Do you wear contacts? Y / N Are you involved in psychotherapy? Y / N

What is your current exercise program and diet (sugar/caffeine/alcohol)? \_\_\_\_\_

What does a typical day look like for you? \_\_\_\_\_

How did you find out about Roling? \_\_\_\_\_ About me? \_\_\_\_\_

Have you received Roling? Y / N Previous bodywork/Roling experience? \_\_\_\_\_

What do you want from Roling, and what are your expectations? \_\_\_\_\_

***Additional information and/or comments may be provided on the back of this form.***

I certify that the above information is true and accurate to the best of my knowledge.

\_\_\_\_\_  
Client Signature (Parent/Guardian for minor)

\_\_\_\_\_  
Date