North Star Integration
Discover physical enlightenment
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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; pancriatitis
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 Rolfing? 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 Rolfing? _____ About me? _____
Have you received Rolfing? Y / N Previous bodywork/Rolfing experience? _____
What do you want from Rolfing, 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