KATE HUGHES
ROLF® + YOGA

KATE HUGHES ROLF YOGA
1290 Yellow Pine ave Boulder, CO 80304
208.863.3023 katehughesrolfyoga.com

CLIENT INTAKE FORM

Name_____ **Date of Birth** _____
Email_____ **Emergency contact** _____
Phone_____ **Emergency contact phone** _____
Address _____

How did you learn about us? _____

Have you received Rolfing or bodywork before? ☐ **Yes** ☐ **No**

Are you on any medication? ☐ **Yes** ☐ **No** **If yes, please list:** _____

Are you currently in pain? ☐ **Yes** ☐ **No** **If yes, please describe:** _____

Are you currently receiving treatment from other practitioners (physician, chiropractor, therapist, etc.)? ☐ **Yes** ☐ **No**
If yes, please describe: _____

_____

Health History **Please mark any of the following conditions you may currently have.

- ☐ Heart Condition
- ☐ High/Low Blood Pressure
- ☐ Blood Disorders
- ☐ Diabetes
- ☐ Cancer
- ☐ Thydroid Problems
- ☐ Autoimmune disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Currently Pregnant
- ☐ Numbness/Tingling
- ☐ Whiplash
- ☐ Concussion
- ☐ Traumatic Brain Injury
- ☐ TMJ Pain/Dysfunction
- ☐ Epilepsy
- ☐ Dizziness
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Nervous System Disorder
- ☐ Circulatory Disorder
- ☐ Respiratory Disorder
- ☐ Asthma
- ☐ Chronic Fatigue
- ☐ Grief Process
- ☐ Anxiety and/or Depression
- ☐ Long COVID
- ☐ Fever within 24 hours
- ☐ Other - please specify below

_____

Please elaborate on any yes answers in the space provided below:

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What brings you to this work and what are your primary goals for treatment?

_____

_____

_____

What physical activities do you enjoy?

_____

_____

_____

Please list any accidents, surgeries or injuries:

_____

_____

_____

_____

Anything else you want me to know:

_____

_____

_____

I have completed this form to the best of my ability/knowledge and agree to inform the Certified Rolfer of any changes in the above information. This form is used as a guide and starting point. There will be further discussion with your Certified Rolfer.

Printed Name _____

Signature _____ **Date** _____