



KATE HUGHES ROLFING
160 E 12th Street Suite 2 Durango, CO 81301
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.

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

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 _____

