



# LotusHeart

## BODYWORKS

### Health History Intake

Name \_\_\_\_\_ Phone (    ) \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail: \_\_\_\_\_

Referred by: \_\_\_\_\_ Occupation \_\_\_\_\_

In case of emergency: \_\_\_\_\_ Phone (    ) \_\_\_\_\_

Primary Health Care Provider \_\_\_\_\_

**Please read and answer the following questions carefully regarding your medical history, symptoms and injuries. Rolf Structural Integration may be contraindicated for certain conditions and may require consent from your primary care provider.**

- |   |   |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have diabetes? <input type="checkbox"/> I <input type="checkbox"/> II | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have varicose veins?                  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant?  | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any contagious diseases?         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing dentures or dental implants?                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have osteoporosis?                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have high blood pressure?   | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any allergies?                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you taking high blood pressure medication?                               | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you bruise easily?                        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from epilepsy or seizures?                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have cardiac or circulatory problems? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you experience frequent headaches?  |   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have arthritis? Please specify _____                                  |   |

Yes  No Do you experience joint swelling? If so, where and frequency? \_\_\_\_\_

Yes  No Do you take medications? Please specify \_\_\_\_\_

Yes  No Do you experience back pain? If so, where and frequency? \_\_\_\_\_

Yes  No Do you have numbness or stabbing pains? Please specify \_\_\_\_\_

Yes  No Have you been a victim of sexual or physical abuse? If so, have you received any therapy or counseling? \_\_\_\_\_

Please list any other medical conditions not mentioned above. \_\_\_\_\_  
\_\_\_\_\_

Please list areas of your body where you experience pain or discomfort. \_\_\_\_\_  
\_\_\_\_\_

Please list injuries, major illnesses, and traumatic events you have experienced in the past two years. \_\_\_\_\_  
\_\_\_\_\_

Please list major injuries, illnesses, and surgeries in your life which currently effects your physical or mental health. \_\_\_\_\_  
\_\_\_\_\_

Please list major injuries, illnesses, and surgeries in your life which currently effects your physical or mental health. \_\_\_\_\_  
\_\_\_\_\_

Is there anything else you would like me to know regarding your health history? \_\_\_\_\_  
\_\_\_\_\_

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\_\_\_\_\_

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\_\_\_\_\_

I understand the purpose of Rolf Structural Integration (SI) is to balance and align the physical body so that it is supported and maintained by gravity in three-dimensional space. This is done through direct movement of the body connective tissue (fascia) and education so that greater economy and freedom of body movement is achieved. I understand that Matthew Hartman, LMT, Practitioner of Rolf SI makes no warranties or guarantees regarding the results of this process.

I understand that Rolf SI is not involved with the treatment of disease, illness, or disorders of any kind, nor does it substitute for medical diagnosis or treatment when such attention is needed. With my signature I give consent for Rolf SI bodywork and at anytime during the treatment I have the right to withdraw this consent.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

*Consent to Treatment of Minor:* By my signature below, I hereby authorize Matthew Hartman, LMT to administer Rolf SI bodywork to my child or dependent as he deems necessary.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_