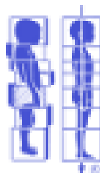

James McCormack
Rolfing Structural Integration

PERSONAL HISTORY FORM AND HEALTH QUESTIONNAIRE

Name……………………………………………………………………………………

Address………………………………………………………………………………….

Phone………………………………….Mobile……………………………………....

Email……………………………………………………………………………………

Date of Birth……………………….. Height………………Weight…………………..

Have you ever received Rolfing sessions (whom and when)?…………….………….

What other bodywork treatment have you had (what and when)?……………………...

Do you have any acute or chronic pains?…………………......…………………….
………………………………………………………………………………………..

Have you had any fractures or operations?..…………………………………………
………………………………………………………………………………………..

Have you had, or are you having, psychotherapy or psychiatric treatment?………...….

What illnesses have you had in the last 12 months?…………...………………………
………………………………………………………………………………………..

What medication have you taken in the last 6 months?……….……………………..
………………………………………………………………………………………..

Do you have or have you had any of the following: -

❑ Aneurysm	❑ Arthritis (R or O)	❑ Cancer
❑ Connective tissue disease	❑ Diabetes	❑ Disc problems
❑ Epilepsy Haemophilia	❑ Heart condition	❑ High blood pressure
❑ Impaired elimination conditions	❑ Joint problems	❑ Muscle cramps or nerve problems
❑ Osteoporosis	❑ Stroke	❑ Varicose veins

For women (because of abdominal work):-

Do you wear a coil?…………………………

Are you pregnant (months)?…………………………..

Do you wear contact lenses, hearing aid, dentures or a bridge?………………………

What goals are you hoping to achieve with Rolfing?……………………….…………