Structural Integration – Inspired by the teachings of Dr. Ida P. Rolf Form version: Mar/6/2017

Personal History Form

(Confidential)

Name: _____ Home Ph. (Eve) (_____) _____ - _____

Street: _____ Work Ph. (Day) (_____) _____ - _____

City/State/Zip: _____ Mobile/ Cell Ph.(_____) _____ - _____

D.O.B. _____ Age _____ Sex: M / F Ht. _____ Wt. _____

Occupation: _____ Email:_____

How did you hear about us? **Can we inform you of new info & opportunities?** _____

Healthy Habits /Activities	
Major physical injuries / disabilities / concerns / Physical discomforts (note specific stressors)	
Therapy goals (be specific)	

Do you wear contacts and / or dental appliances?	Yes	No		Ever been in manual or physical therapy? (Past or present)	Yes	No
Do you wear arch supports and / or depend upon surgical implants?				*(**Men**/Women) Sexual difficulties,* *(Women) Menstruation, or other difficulties?*		
Are you now under treatment / or medication?				*(Women) Are you pregnant?* *(Women) Do you use an IUD?*		
Comments:				Comments:		

Consulting Physicians and other Health Care Team Providers: (Name, Address, City, State, Zip, Phone, Fax, Optional Comment)

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Regarding my dependent minor, or me, I give my manual therapist permission to consult with listed health care providers and/or the relevant services of the Conscious Health Collaborative regarding health, treatment, billing, and scheduling logistics. I contract to participate fully as a member of this health care team, making sound choices regarding treatment based upon my experience of information and suggestions provided by this health care team. It is my choice to receive manual therapy, and I give my consent to receive treatment. I agree to participate in the self-care program we select and promise to inform my practitioner of changes in health or any time I feel well-being is compromised.

Date: _____ Signature: _____