MATTHEW
BEREAN ROLFING®
CERTIFIED ROLFER™

Client Health Information

____
TODAY'S DATE

How were you referred to Rolfing?

Have you been Rolfed before? no ❑ yes ❑ If yes, when? Please describe your experience :

Previous bodywork experience? ❑ Acupuncture ❑ Craniosacral ❑ Chiropractic ❑ Massage ❑ Physical Therapy ❑ other

Please explain:

Are you under the care of a physician for treatment of a current condition? no ❑ yes ❑ If yes, please explain:

Are you taking medication prescribed by a physician? no ❑ yes ❑ If yes, please explain:

Women: Are you pregnant? no ❑ yes ❑ If yes, what trimester?

ANY HISTORY OF (please check those that apply):

❑ Car accident	❑ Heart condition	❑ Cancer	❑ Low blood pressure	❑ High blood pressure
❑ Diabetes	❑ Respiratory disorder	❑ Asthma	❑ Digestive disorder	❑ Epilepsy
❑ Osteoporosis	❑ Headaches	❑ Migraines	❑ Arthritis	❑ Head injures
❑ Broken bones	❑ Sprains	❑ Mental / nervous disorder		

Please elaborate on any checked items:

Do you have any chronic complaints? If yes, please explain:

What, if anything, have you found to help with your current situation?

What would you like to experience from Rolfing? What are your Rolfing goals?

Additional information and / or comments:

Matthew Berean ◎ 617.538.3342
WWW.MATTHEWBEREAN.COM ◎ ROLFING@MATTHEWBEREAN.COM