Peninsula Rolfing®

HEALTH QUESTIONNAIRE - PLEASE PRINT CLEARLY

Name _____ Date: _____

Address _____

_____

Phone (h)_____ (w)_____ Date of Birth _____

Cell Phone _____

Occupation _____ Email _____

Do you have any of the following conditions/illnesses/problems? Circle (Y) for yes or (N) for no

1.	Heart Condition	Y	N	12.	Respiratory Problems	Y	N
2.	High/Low Blood Pressure	Y	N	13.	Eliminatory Problems	Y	N
3.	Hemophilia (blood disorder)	Y	N	14.	Circulatory Problems	Y	N
4.	Diabetes	Y	N	15.	Digestive Problems	Y	N
5.	Cancer	Y	N	16.	Contact Lenses	Y	N
6.	Convulsions	Y	N	17.	Dentures/Removable Bridge	Y	N
7.	Thyroid Problems	Y	N	18.	HIV	Y	N
8.	Osteoporosis (bone mass)	Y	N	19.	Headaches/Migraines	Y	N
9.	Arthritis	Y	N	20.	Knocked unconscious	Y	N
10.	Osteomyelitis (bone disease)	Y	N	21.	Other, explain below	Y	N
11.	Phlebitis	Y	N		_____		

22. Are you presently under the care of a medical physician/chiropractor/therapist? Y N
If yes, for what? _____
If not, date of last physical_____
What medications have you taken in the past 6 months? _____

23. Do you have any chronic bodily discomfort? _____ _____
_____

24. What is your current exercise program and diet? _____
_____

25. What do you hope to gain from your Treatments?

26. How did you learn about Peninsula Rolfing?
(Please be specific for referral reward program)

Consent for Rolfing Structural Integration

I understand that the Rolfing Practitioner (hereinafter "Practitioner") is not a physician and does not diagnose illness, disease or any other physical or mental disorder. The Practitioner does not prescribe medical treatment or pharmaceuticals. Nothing said or done by the Practitioner should be misconstrued as actual medical advice, medical treatment or medical diagnoses. Any information provided by the Practitioner is for educational purposes only. The Practitioner makes no promises or guarantees about his/her work.

I understand that Rolfing is not a substitute for medical examination or diagnosis, and that it is recommended that I see a physician before beginning any program of physical conditioning or bodywork and for any physical or mental ailment(s) that I may have.

I fully understand that the purpose of Rolfing is to balance and align the physical body. This is done through direct manipulation of the body and education so that greater economy and freedom of body movement are achieved. I give the Practitioner my permission and consent to do all those things necessary in helping me establish balance and alignment, including, but not limited to touching my body. I give the Practitioner full privilege and license to work on my body in order to assist me in establishing balance and alignment therein.

I understand that if I become uncomfortable for any reason that I may ask the Practitioner to end the Rolfing session, and they will end the session. I understand that Rolfing/bodywork is not sexual in any manner and that any illicit or suggestive remarks or behavior on the client's part will result in an immediate termination of the Rolfing session.

The Rolfing Practitioner must be aware of any existing physical conditions and I affirm that I have stated any and all known medical conditions, physicians consulted about the medical conditions, pharmaceuticals and/or treatments prescribed by a physician, alternative medicines I take and any alternative therapies I receive. I will continue to update and inform the Practitioner of any conditions of my physical or mental health and I understand that it is my duty to inform the Practitioner of any changes in my physical or mental health.
If I experience any pain or discomfort during this/these session(s), I will immediately inform the practitioner so that the pressure, procedure, and/or exercise may be adjusted to my level of comfort.

I understand that if I need to reschedule an appointment for any reason, I will give at least 24 hours notice or be responsible for the session fee. If I don't call or show up, I will be responsible for the full session fee.

I certify that the above information is true and accurate to the best of my knowledge.

Signature of Client Date

Signature of Client or Guardian if under 18 yr. of age Date