HEALTH QUESTIONNAIRE

Name _____ Referred by _____

Address _____ City _____ ZIP _____

Phone _____ Email _____

Occupation _____ Height _____ Age _____

Please circle Y if you have had any of the following:

Heart condition	Y	Chiropractic care	Y
Cancer	Y	Thyroid problems	Y
Arthritis	Y	Diabetes	Y
Convulsions	Y	Osteoporosis or osteomyelitis	Y
Phlebitis or hemophilia	Y	Orthopedic braces or shoes	Y
Kidney or urinary problems	Y	High or low blood pressure	Y
Contact lenses	Y	Dentures or removable bridge	Y
Allergies	Y	Hernias	Y
Sinus problems	Y	Pregnancy (current)	Y
Whiplash	Y	Surgical pins/plates	Y
Scoliosis	Y	TMJ syndrome	Y
Chronic or recurrent pain	Y	Cosmetic surgery	Y
Headaches	Y	Respiratory disorder	Y
Ulcer or digestive disorder	Y	Degenerative joint disease	Y

Have you had any broken bones or major sprains? _____ Briefly describe: _____

_____

Any major injuries, illnesses or accidents? _____ Briefly describe: _____

_____

Have you had any surgery? _____ Briefly describe: _____

_____

What medications have you taken during the last six months? _____

Are you being treated by a medical or chiropractic doctor? _____

Are you presently in psychological therapy? _____

Describe any chronic or recurrent pain: _____

Are there any activities from which you are restricted? _____

What kind of exercise do you do regularly? How many hours per week? _____

Why are you interested in Rolfing® Structural Integration? _____

Have you had Rolfing or other types of bodywork in the past? _____

CANCELLATION POLICY: Due to the large amount of time that must be blocked out for each appointment, it is necessary to require **24 hours notice** of all cancellations or the full fee will be charged.

I certify that the above information is true and accurate to the best of my knowledge, and I agree to keep my appointments in a timely manner.

Signature _____ Date _____