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HEALTH QUESTIONAIRE – PLEASE PRINT CLEARLY

Name _____ Date _____

Address _____ DOB _____

_____ Email _____

Phone (H/C)_____ Occupation _____

(W)_____

1. Circle any of the following that apply to you: (Y= Yes, N= No)

a.	Heart Condition	Y	N	l.	Respiratory Problems	Y	N
b.	High / Low Blood Pressure	Y	N	m.	Eliminatory Problems	Y	N
c.	Hemophilia	Y	N	n.	Circulatory Problems	Y	N
d.	Diabetes	Y	N	o.	Digestive Problems	Y	N
e.	Cancer	Y	N	p.	Contact Lenses	Y	N
f.	Convulsions/Seizures	Y	N	q.	Dentures / Removable Bridge	Y	N
g.	Thyroid Problems	Y	N	r.	I.U.D.	Y	N
h.	Osteoporosis (bone mass)	Y	N	s.	Headaches / Migraines	Y	N
i.	Arthritis	Y	N	t.	Knocked unconscious	Y	N
j.	Osteomyelitis (bone disease)	Y	N	u.	Do you smoke?	Y	N
k.	Phlebitis	Y	N	v.	Deviated septum (nasal)	Y	N

2. Are you presently under the care of a medical physician / chiropractor / therapist / counselor? Y N
   If yes, please explain.

   Please list any medications that you have taken in the last 6 months.

3. Do you have any chronic bodily discomfort? If so, please explain.

4. Have you received any injections (steroidal, botox, novacaine, epidural, etc) in the past 6 months? If so, please explain.

5. What is your current exercise program and diet?

6. Please describe your previous bodywork / massage experience, including frequency of visits. Have you been to a Rolfer before? If so, when and how many sessions?

7. What do you hope to gain from Rolfing?

8. How did you find out about Rolfing Flagstaff?

9. Please describe any major injuries, accidents, or surgeries:

Date	Description	Treatment

Consent

I agree to pay a fee of $140 for each session, at the time service is rendered. I will be charged $30 in addition to bank fees for each returned check. I agree to pay $105 for all missed sessions and $70 for sessions cancelled lacking 24-hour notice.

I understand that Rolfing is not an attempt to diagnose, treat, or cure any disease or medical condition. I understand that Rolfing is not a substitution for medical treatment or other professional healthcare.

I give Gibney Siemion (practitioner) or Justin Salamon (practitioner) permission and consent to establish and restore greater adaptive capacity and alignment in my body, using soft tissue manipulation and movement education. Furthermore, I understand that any relief of physical or emotional symptoms is coincidental, and is not the basic goal of Rolfing.

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I HAVE READ AND AGREED TO THE ABOVE.

Signature:_____ Date:_____

(If client is under 18 years of age, parent or legal guardian must sign)