



The degree of change that makes a world of difference

CONFIDENTIAL HEALTH QUESTIONNAIRE & CONSENT

Name: _____ Height: _____
 Address: _____ Weight: _____
 City: _____ State: _____ Zip: _____ DOB: _____
 Phone: H _____ C _____ Sex: _____
 Email: _____ Referred By: _____

Do you have or have you ever had any of the following conditions/illnesses/problems? Circle Yes (Y) or No (N). Please be descriptive when appropriate.

- | | | | | | |
|----------------------------|---|---|------------------------------|---|---|
| 1. Heart Condition | Y | N | 13. Elimination Problems | Y | N |
| 2. High/Low Blood Pressure | Y | N | 14. Circulatory Problems | Y | N |
| 3. Hemophilia | Y | N | 15. Digestive Problems | Y | N |
| 4. Diabetes | Y | N | 16. Contact Lenses | Y | N |
| 5. Cancer | Y | N | 17. Dentures/Bridge | Y | N |
| 6. Convulsions | Y | N | 18. I.U.D. | Y | N |
| 7. Thyroid Problems | Y | N | 19. Allergies | Y | N |
| 8. Osteoporosis | Y | N | 20. Are you taking Cortisone | Y | N |
| 9. Arthritis | Y | N | 21. Are you taking Statins | Y | N |
| 10. Osteomyelitis | Y | N | 22. Previous Injury to Spine | Y | N |
| 11. Phlebitis | Y | N | 23. Numbness/Tingling | Y | N |
| 12. Respiratory Problems | Y | N | 24. Any Infectious Diseases | Y | N |

25. Are you now under the care of a medical physician/chiropractor/therapist, or other health practitioner? Yes / No. If yes, for what? _____
 If no, date of last physical _____. What medication have you taken in the past 6 months? _____

26. Please describe any past injuries, accidents, and surgeries:

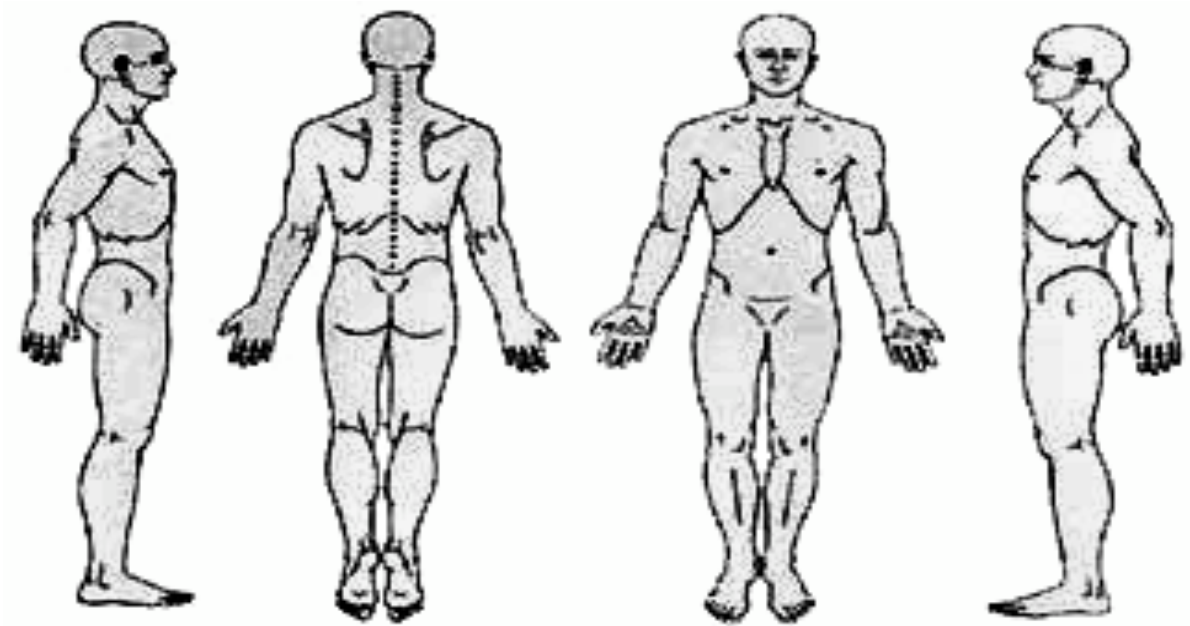
Dates	Areas Affected	Treatment

26. What are your areas of chronic or acute discomfort? _____

27. Have you ever been Rolfed before? If so, how many sessions, and Rolfer's name?

(OVER)

29. Please indicate on the figures below, those places that you sometimes feel chronic or acute pain. Mark an X for acute pain and O for chronic pain



Consent

- I hereby apply for a standard series of processing in *Rolfing* (Structural Integration).
- I fully understand the purpose of *Rolfing* is to balance and align the physical body so that it is supported and maintained by gravity in three-dimensional space. This is done through manual manipulation, Low Level Cold Laser treatment, Percussor, and Adjustor tools, as well as kinesthetic education so that greater economy and freedom of body-movement is achieved.
- I understand *Rolfing* is not involved with the treatment of disease of any kind, nor does it substitute for medical diagnosis or treatment when such attention is needed.
- The Rolfer does not treat, prescribe or diagnose any illness, disease or any other physical or mental disorder of the individual. Nothing said or done by a Rolfer should be misconstrued to be such.
- I understand it is necessary for the Rolfer to touch my body in order to assist me in establishing balance and alignment in my body.
- I give Rolf Practitioner Chris Hodel my permission and consent to do all those things necessary in the scope of *Rolfing* to establish balance and alignment, including, but not limited to touching my body. I give the Rolfer full privilege and license to work on my body in such a way as to restore and establish balance and alignment therein.

Client's Printed Name

Client's Signature

Date