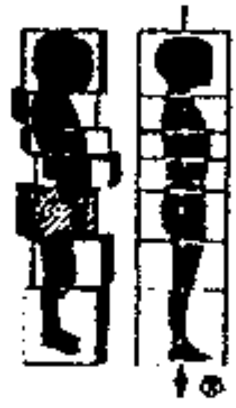

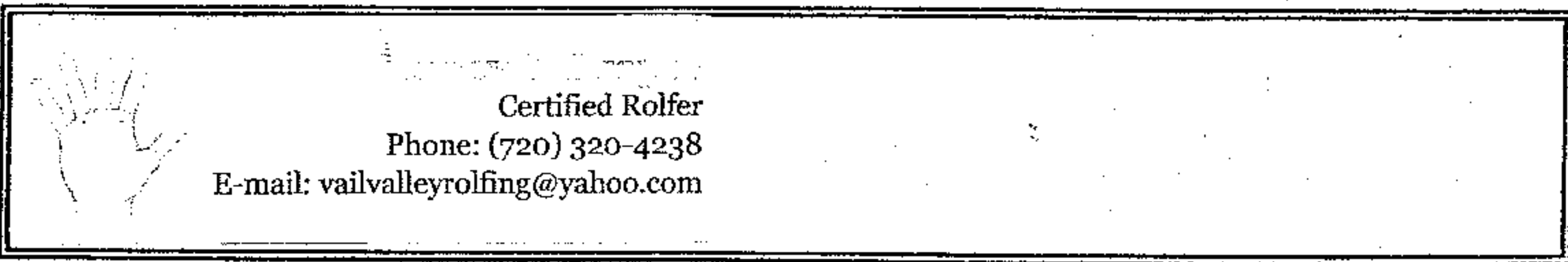

Certified Rolfer
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HEALTH QUESTIONNAIRE - PLEASE PRINT CLEARLY

Name ______________________ Date: ______________________
Address ______________________ Weight: ______________________
______________________ Height: ______________________
Phone (h)__________ (w)__________ Date of Birth ______________________
Occupation ______________________

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.	I.U.D.	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		______________________		

20. 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? ______________________
21. Do you have any chronic bodily discomfort? ______________________
____
22. What is your current exercise program and diet? ______________________
____
22. What is your previous bodywork/massage experience, including how frequent: and if you have had any Rolfing® sessions and when?
____
____
23. What do you hope to gain from Rolfing?
____
24. How did you learn about Rolfing? ______________________
____
25. How did you find out about me? ______________________