CONFIDENTIAL HEALTH QUESTIONAIRE

Name_____ Phone: home _____ cell _____

Address_____ City_____State _____ Zip_____

Date of Birth_____Age_____ □M □F Height _____Weight _____

Email_____ Referred by _____

Occupation_____Have you ever experienced Massage □Y □N or Rolfing®? □Y □N

Approximately how many Rolfing sessions have you had? _____

Are you under the care of a physician, chiropractor, or other healthcare professional? □Y □N If yes, explain:

_____

_____

Do you exercise? □Y □ N If yes, list what kind and how often:

_____

_____

List and describe any medications and supplements/vitamins you take:

_____

_____

Date and describe any injuries and accidents:

_____

_____

_____

Date and describe any surgeries:

_____

_____

_____

Please describe any chronic health issues or acute problems you'd like to address? _____

_____

_____

List your goals for the session (s):

_____

_____

I understand that Massage and Rolfing should not be considered a substitute for medical care or diagnosis. I affirm that I've stated all my known medical conditions and answered questions honestly. I am responsible for payment of any scheduled appointment cancelled less than 24 hours in advance.

Date: _____Signature _____

a path to healing