

CONFIDENTIAL HEALTH QUESTIONNAIRE

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:

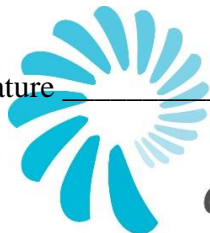
Date and describe any surgeries:

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