



Karin Edwards
Certified Rolfer®
503-230-0087

Confidential Health Questionnaire

Name: _____ Date: _____
 Address: _____ D.O.B.: _____
 _____ Zip: _____ Occupation: _____
 Phone: (H) _____ (W) _____ Email: _____
 (Cell) _____

Have you ever had any of the following conditions or problems? Be descriptive if appropriate.

Heart condition	Y	N	Respiratory problems	Y	N
High/low blood pressure	Y	N	Eliminatory problems	Y	N
Hemophilia	Y	N	Circulatory problems	Y	N
Diabetes	Y	N	Digestive problems	Y	N
Cancer	Y	N	Dentures/removable bridge	Y	N
Convulsions	Y	N	Jaw tension or TMJ	Y	N
Thyroid problems	Y	N	Hearing loss	Y	N
Osteoporosis	Y	N	Pregnant	Y	N
Arthritis	Y	N	HIV, AIDS	Y	N
Phlebitis	Y	N	Other _____		

1. Are you presently under the care of a medical physician/chiropractor/therapist/acupuncturist? _____
 If yes, for what? _____ Provider's Name _____

2. What medication have you taken in the past six months? _____

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

4. Do you have any areas of chronic bodily discomfort? _____

5. How do you use your body? Please list current diet, exercise, sports, hobbies or musical instruments.

6. Have you received, or do you regularly receive some form of massage/bodywork? How often?

7. Have you ever received Rolwing® before? If so, how many sessions? _____

8. What would you like to gain from your experience with Rolwing®? _____

9. Will you seek reimbursement from an auto claim, health insurance, flex plan account, etc? Y/N

10. How did you hear about me? _____

I certify that the above information is true and accurate to the best of my knowledge.

 Client Signature (or Parent/Guardian if under 18 years of age)

 Date

APPLICATION AND CONSENT FOR ROLFING®

I hereby apply for one, or a series of sessions in Rolfing® *Structural Integration* for

- myself.
- _____ for whom I am the legal guardian.

I understand that the purpose of Rolfing® is to balance and align the physical body so that it is supported by gravity in three-dimensional space. This is done through direct manipulation and education so that greater economy and freedom of body movement are achieved.

I understand that 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 an illness, disease, or any other physical or mental disorder of the person. 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 the body.

I give Karin Edwards, as a Certified Rolfer®, my permission and consent to do all those things necessary in helping me 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.

Furthermore, I understand that any relief of physical or emotional symptoms is coincidental in the organization of the total human being and is not the basic goal of Rolfing®.

I understand that I may be charged for missed sessions with less than 24 hours notice.

Client Signature (or parent/guardian if under 18 years of age)

Date

(Optional)

I give Karin Edwards, Certified Rolfer®, my permission to contact my health providers (listed below or on first page of this form) and discuss my health care treatment.

Client Signature (or parent/guardian if under 18 years of age)

Date