



**Karin Edwards Wagner, Certified Rolfer™**  
**1707 SE 33<sup>rd</sup> Ave., Portland, OR 97214**  
**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. List 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, or for a child 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 Wagner, 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 will be charged for missed sessions with less than 24 hours notice. \_\_\_\_\_  
(initial)

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

### Optional:

I give permission to discuss my health care treatment with my health providers (listed below or on first page of this form). For motor vehicle claims, I give permission for my chart notes and other health information to be shared as needed.

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