ROLFING® Health Questionnaire, Application and Consent Form

(Confidential)

Name: ____ Gender: ________

Address: ____ Height: __________

City: ____________________State:_____________ZIP:_________ Weight: ________

Telephone:day__________________evening: _________________ DOB: __________

E-mail address: ____

I was referred by:____

Do you have or have you ever had any of the following conditions/illnesses/problems? Circle YES (Y) or NO (N). Be descriptive when appropriate.

1.	Heart Condition	Y	N	13.	Elimination Problems	Y	N
2.	High/Low Blood Pressure	Y	N	14.	Circulatory Problems	Y	N
3.	Hemophilia	Y	N	15.	Digestive Problems	Y	N
4.	Diabetes	Y	N	16.	Contact Lenses	Y	N
5.	Cancer	Y	N	17.	Dentures/Removable Bridge	Y	N
6.	Convulsions	Y	N	18.	I.U.D.	Y	N
7.	Thyroid Problems	Y	N	19.	Allergies	Y	N
8.	Osteoporosis	Y	N	20.	Are you taking cortisone	Y	N
9.	Arthritis	Y	N	21.	Any Injury to Spine	Y	N
10.	Osteomyelitis	Y	N	22.	Varicose Veins	Y	N
11.	Phlebitis	Y	N	23.	Numbness/Tingling	Y	N
12.	Respiratory Problems	Y	N	24.	Any infectious diseases (Hepatitis, HIV, Herpes, other)	Y	N

25. Are you now under the care of a medical physician/chiropractor/therapist or other health practitioner? **Yes / No.** If yes, for what?_____________________________________ If not, date of last physical ___________________. What medication have you taken in the past 6 months? ____.

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

Dates	Areas Affected	Treatment

27. Do you have any areas of chronic bodily discomfort?______________________________

____

28. Have you ever been Rolfed before? If so, how many sessions? ______________AND the Rolfers name:____.

(continue to 2nd page)

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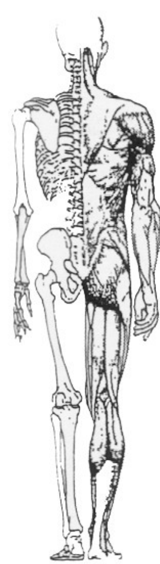
29. Please indicate on the figures below those places that you sometimes feel pain.



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

I understand Rolfing Structural Integration 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.

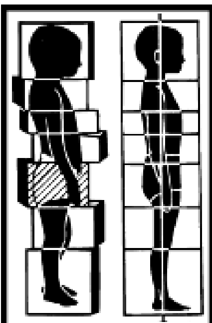
I understand that the Rolfer does not treat, prescribe or diagnose an illness, disease, or any other physical or mental disorder of the person. Nothing said or done by a Rolfer should be misconstrued to be such.

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 **MARK HUTTON** 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.

I understand that the Rolfer may use, by mutual agreement with me, an Erchonia Low Level Cold Laser, cleared by the FDA for the safe and effective use on joint pain and stiffness: and that the use of this revolutionary new tool is currently beyond the generally accepted definition of "hands-only" Rolfing. However, the laser may be used in a session according to the new Standards of Practice.

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 Structural Integration.



Date: ____________________________

Witness: ____________________________

____
Signature

____
Address

____
City *State* *Zip*

____
Phone Number