Lilah Wallach
Certified Rolfer®
503-730-9308

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 Rolfing® before? If so, how many sessions? _____
8. What would you like to gain from your experience with Rolfing®? _____
_____

9. 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 Lilah Wallach, 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 Lilah Wallach, 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