

Health Questionnaire

Welcome. This questionnaire helps me understand your body and your health history so I can work with you safely and effectively. Everything you share is kept confidential.

1 CONTACT INFORMATION

Name _____ Today's date _____

Email _____ Phone _____

Address _____ Date of birth _____

City, state, zip _____ Gender / pronouns (optional) _____

EMERGENCY CONTACT

Name _____ Relationship _____ Phone _____

2 HEALTH HISTORY

Do you have, or have you had, any of the following? Check any that apply.

- | | | |
|--|--|---|
| ☐ Heart condition | ☐ High or low blood pressure | ☐ Blood clots or phlebitis |
| ☐ Hemophilia or bleeding disorder | ☐ Diabetes | ☐ Cancer (current or past) |
| ☐ Seizures | ☐ Thyroid problems | ☐ Osteoporosis |
| ☐ Arthritis | ☐ Autoimmune condition | ☐ Respiratory problems |
| ☐ Circulatory problems | ☐ Digestive or eliminatory problems | ☐ Numbness or tingling in limbs |
| ☐ Headaches | ☐ Dizziness | ☐ Back pain |
| ☐ Herniated disc | ☐ Joint replacement or implants | ☐ Recent surgery or fracture (past 6 months) |
| ☐ Pregnant or possibly pregnant | ☐ Skin conditions or sensitivities | ☐ Other: _____ |

FOR HEAD AND FACE WORK

- | | | |
|---|---|---|
| ☐ Contact lenses | ☐ Removable bridge or dentures | ☐ Braces or orthodontics |
|---|---|---|

3 MEDICAL CARE & MEDICATIONS

Are you currently under medical care?

☐ Yes ☐ No If yes, for what? _____

Are you currently taking any medications, including blood thinners or pain medication?

☐ Yes ☐ No If yes, please list _____

Past injuries, accidents, and surgeries

YEAR	AREA AFFECTED	TREATMENT
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4 YOUR BODY & YOUR GOALS

Do you have any areas of chronic discomfort? Where, and for how long?

What kinds of exercise or movement do you enjoy?

What is your previous experience with bodywork or massage?

Have you received Rolfing® Structural Integration before?

☐ Yes ☐ No If yes, how many sessions, and when? _____

What would you like to gain from your Rolfing sessions?

Is there anything that would help you feel comfortable with touch, pressure, or the work itself? (optional)

How did you hear about my work? _____

Policies & Consent

IMPORTANT POLICIES

- Cancellations require 24 hours' notice, or the full session fee will be charged.
- If you are ill, please contact me so we can reschedule your appointment.
- If you have any questions or concerns about your Rolfing process or what you are experiencing, please contact me.
- Payment by cash, check, credit card, or Venmo is due in full at each session.
- If you need a receipt for insurance or HSA/FSA purposes, please let me know before each session.

APPLICATION & CONSENT FOR ROLFING®

I hereby apply for Rolfing® Structural Integration sessions and certify that the above information is true and accurate to the best of my knowledge. I understand the purpose of Rolfing Structural Integration is to balance and align the body so that it is supported by gravity in three-dimensional space. This is done through hands-on work and movement education, so that greater ease and freedom of body and movement are achieved.

I understand 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 any illness, disease, or other physical or mental disorder. Nothing said or done by the Rolfer should be misconstrued as such.

I understand it is necessary for the Rolfer to touch my body in order to assist me in establishing balance and alignment. I give Gary Gurney, Certified Rolfer™, my permission and consent to do those things necessary in helping me establish balance and alignment, including touching my body. I understand that I may ask to adjust the pressure, pause, or stop the work at any time.

I understand that any relief of physical or emotional symptoms is a byproduct of organizing the whole person and is not the basic goal of Rolfing.

All records maintained by the Rolfer are confidential and require written approval from the client to be released to anyone other than the client.

By signing below, I acknowledge that I have read, understood, and agree to the policies and information above.

Client name (printed) _____

Date _____

Client signature _____

Date _____