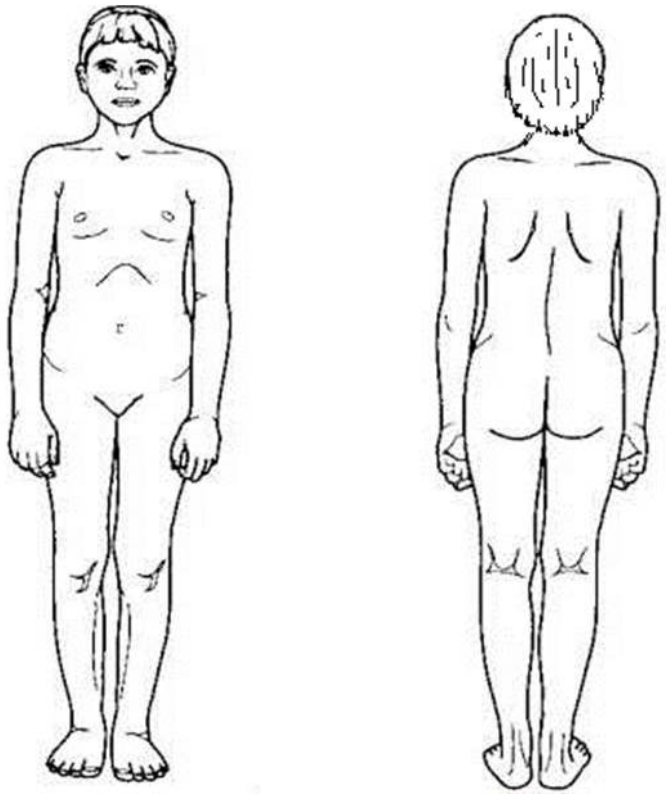
ROLFING – PERSONAL DATA AND HEALTH QUESTIONNAIRE

PLEASE PRINT LEGIBLY

FULL NAME:					DATE:		
POSTAL ADDRESS:					SEX:	Male	Female
					HEIGHT:		
TELEPHONE:	H:		W:		WEIGHT:		
	C:		F:		Date of Birth:		
e-mail address			OCCUPATION:				
Briefly describe your work situation: environment, hours worked, etc.							
Where did you first find out about Rolfing?							

Mark with an X any areas of *pain, stiffness, numbness, tingling or loss of strength.*



There will be time for more discussion on these and other issues as we proceed. Please feel free to ask questions about the Rolfing method at any point in the session.

What treatment have you previously had for these symptoms?
Are you currently under a physician's care?
Do you or your doctor believe that you have any illness at the present time and if so, what?
If you are under the care of a physician,he/she know you are being treated via soft tissue therapy?

Do you, or have you suffered from or experienced any of the conditions below:

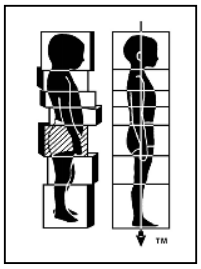
Condition	Yes/ No	Approximate Date	Condition	Yes/ No	Approximate Date
Alcohol/drug problem			High/Low blood pressure		
Allergy (Specify)			Communicable Disease		
Arthritis			Infectious Diseases		
Asthma / hayfever			Contagious Diseases		
Back trouble			Insomnia		
Birth trauma			Kidney trouble		
Bursitis			Mental illness		
Cancer			Nervous anxiety		
Chronic Pain			Open cuts or sores		
Constipation			Osteoporosis		
Contact lenses			Phlebitis		
Diabetes			Currently Pregnant?		
Digestive tract			Respiratory trouble		
Ear trouble			Rheumatism		
Emphysema			Scoliosis		
Epilepsy			Sinus trouble		
Eye/ear/nose/throat			Skin problem		
Headaches			Urogenital		
Heart condition			Varicose Veins		
Hernia			Vomiting		

OPERATIONS: Type & approximate date - how did these operations effect you?	
ACCIDENTS, INJURIES OR ILLNESSES: (Particularly fractures, concussions and dislocations): Have you had any surgery in the last year?	
MAJOR DENTAL WORK: Extractions, TMJ problems, teeth grinding	
PREGNANCIES: How many pregnancies and births.	
Briefly describe the type and frequency of exercise you get each week:	
Do you have any general, non-specific complaint or limitation?	
Any condition or history that I should be aware of?	
Any specific areas that you want me to avoid?	
Any specific area you want me to concentrate on?	
What would you like to get out of these sessions?	

I understand that I will be charged in full for appointments not cancelled at least 24 hours in advance.

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

Signed: **Date:**



BERYL BLAESER

Certified Rolfer and Movement Practitioner

Client Consent Form

ROLFING™ Structural Integration

I hereby give consent to receive Rolfing structural integration.

I fully understand that the purpose of Rolling 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 the greater economy and freedom of body movement is achieved. However, I understand that the Rolfing Practitioner makes no warranties or guarantees regarding the results of the Rolfing process.

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 any other physical or mental disorder of the person. Nothing said nor done by the Rolfer should be construed as such.

I understand it is necessary for the Rolfer to physically contact my body in order to assist me in establishing balance and alignment in my body.

I hereby give **Beryl Blaeser, Certified Rolfer and Movement Practitioner**, my permission and consent to do those things necessary to assist me in establishing balance and alignment, including physical contacting my body in such a way as to restore the balance establish balance and alignment thereof.

I understand that I may at any time revoke such consent and discontinue the process of Rolfing.

Furthermore, I understand that any relief of physical and emotional symptoms is coincidental to the organization of my being and is not the basic goal of Rolfing.

APPOINTMENT & CANCELLATION POLICY

I understand that the Rolfing practitioner agrees to perform Rolfing during my scheduled appointment time only. I understand that if I am late for an appointment, it may not be possible to change the end time of the session and that I will still be responsible for the payment in full of the scheduled session.

Furthermore, I agree to give notice of cancellation at least 24 hours in advance of my appointment. If I do not give such notice, then I assume responsibility for payment in full of the scheduled session. Exceptions may be made at the discretion of the Rolfer in the case of unforeseen illness or emergencies.

Client Name: _____

Signature of Client: _____ Date: _____