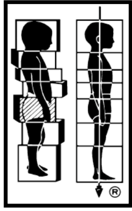

Redwood Empire Rolfing®

3452 B Mendocino Avenue
Santa Rosa, CA 95403
TEL/FAX: 707-542-2001
Email: carole34@comcast.net
www.redwoodempirerolfing.com

HEALTH INFORMATION

Name(Print) ______________________ Date ______________

Address ______________________ Phone(home) ______________

City ____________ State ____ Zip ______ (work) ______________

E-mail address ______________________ (mobile) ______________

Occupation ______________ Avocation ______________

Height __________ Weight __________ Date of Birth __________

How were you referred to **Rolfing**? ______________________

Have you been Rolfed before? _____ How many sessions? _____ By whom? ________

Health Information

Are you under the care of a physician? _____ Does he/she approve of you being Rolfed? _____

Are you on any medication prescribed by a physician? _____ What? ______________

Do you use aspirins or any other non-prescription drugs? ______________

What type and how often? ______________________

Are you involved in psychotherapy? ________ Do you exercise regularly? ________

Please describe your physical activities ______________________

Have you ever worn braces? ________ Do you wear contact lenses? ________

Women: Are you pregnant? ________

Any History of:

	Yes	No		Yes	No
Heart Condition	☐	☐	Cancer	☐	☐
High Blood Pressure	☐	☐	Diabetes	☐	☐
Arthritis	☐	☐	Respiratory disorder	☐	☐
Osteoporosis	☐	☐	Asthma	☐	☐
Ulcer/Digestive disorder	☐	☐	Epilepsy	☐	☐
Mental/nervous disorder	☐	☐	Phlebitis	☐	☐
Genito-urinary disorder	☐	☐	Birth Defects	☐	☐

Do you have radiating pain in any limbs? ________ Numbness or tingling? ________

Eye, ear, nose or throat disorder?________ Do you have chest pains during exertion?________

Do you have any contagious or communicable disorders - describe__________________________

Do you have any disability of the feet, ankles, hips, or back?________ Explain ______________

____

Do you have any illness or injury at the present time? _______ Describe ____________________

____

Please list all operations, accidents, injuries or serious illnesses you have had ________________

____

Do you have any chronic complaints (things you have given up on and accepted, i.e., headaches, constipation, etc.)____

Do you feel tired very often?______ How do you relax?__________________________________

Why do you want to be Rolfed, and what are your expectations?___________________________

____

Additional information or comments you would like to add_______________________________

____

Office Policies

24 hour Cancellation Policy
Please be mindful I have a 24 hour Cancellation Policy. If you cancel (or miss your appointment) within 24 hours, you will be charged for your appointment time. I understand that emergency situations arise. If a replacement can be found for your appointment time this charge will be waived. However, with less than 24 hours notice you may be charged for your missed appointment.

Reminder Calls
I do not make reminder calls. Please put your appointment in your calendar. Once the appointment is scheduled, it is your responsibility to remember it. You may call me at any time to check on your appointment and I will get back to you right away.

Payments
Payment for service is due at the time of your visit. Cash, personal check or credit card is accepted. A $25 fee will be incurred for returned checks.

I welcome referrals, which signify your satisfaction and trust in my services.

Signed ______________________________________ Date ___________________

Witness______________________________________ Date ___________________
(Parent or guardian of minor)