

Gary Gurney Certified Rolfer™

83 India St. Portland, ME 04101

E-Mail garyjgurney@gmail.com Web www.mainerolfing.com

HEALTH QUESTIONNAIRE

Name: _____

E-Mail _____

Address: _____

Date: _____

Birthdate: _____

Phone(s): _____

Gender: _____

Do you have or have you had any or the following conditions, illnesses or problems?
Please circle Yes (Y) or No (N).

- | | | | |
|----------------------------|-----|---------------------------|-----|
| 1. Heart Condition | Y N | 12. Eliminary Problems | Y N |
| 2. High/Low Blood Pressure | Y N | 13. Circulatory Problems | Y N |
| 3. Hemophilia | Y N | 14. Digestive Problems | Y N |
| 4. Diabetes | Y N | 15. Contact Lenses | Y N |
| 5. Cancer | Y N | 16. Removable Bridge | Y N |
| 6. Convulsions | Y N | 17. Orthodonture (Braces) | Y N |
| 7. Thyroid Problems | Y N | 18. Extremity Numbness | Y N |
| 8. Osteoporosis | Y N | 19. Headaches | Y N |
| 9. Arthritis | Y N | 20. Dizziness | Y N |
| 10. Phlebitis | Y N | 21. Back Pain | Y N |
| 11. Respiratory Problems | Y N | 22. Herniated Disc | Y N |

Are you currently under medical care? Y N

If YES, for what? _____

Are you currently taking any medications? Y N

If YES, please list: _____

Please List past injuries, accidents and surgeries:

Dates	Area(s) Affected	Treatment

Do you have any areas of chronic bodily discomfort?

What kinds of exercise do you do?

What is your previous experience with bodywork/massage?

Have you received Rolfing Structural Integration before? If so, how many sessions?

What would you like to gain from you experience of receiving Structural Integration?

IMPORTANT POLICIES

- Cancellations require 24 hours notice or the full session fee will be charged.
- If you have an illness, contact me so we can reschedule your appointment.
- Payment in cash, check, or credit card is due in full at each session, unless prior arrangements have been made.
- Please advise me if you need a receipt for insurance purposes prior to each session.
- If you have any questions or concerns about your Rolfing process or what you are experiencing, please contact your me.

APPLICATION & CONSENT FOR ROLFING®

I hereby apply for a standard series of processing in Rolfing® Structural Integration and certify that the above information is true and accurate to the best of my knowledge. I fully understand the purpose of Rolfing® 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 economy and freedom of body 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 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 **Gary Gurney 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®.

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

Client's Signature _____

Date _____