DAN GENTRY – CERTIFIED ROLFER

HEALTH QUESTIONNAIRE

OFFICE 942-5100 HOME 721-4345

OFFICE POLICY

YOUR APPOINTMENT IS TIME THAT IS SET ASIDE ESPECIALLY FOR YOU. BECAUSE THERE IS A WAITING LIST OF PEOPLE WHO NEED TO GET IN, ***A 24-HOUR CANCELLATION NOTICE IS REQUIRED.*** IF THIS IS NOT HONORED THERE WILL BE A CHARGE FOR YOUR APPOINTMENT. PLEASE FEEL FREE TO CALL ME AT THE OFFICE OR AT HOME IF A CANCELLATION IS NECESSARY. THANK YOU IN ADVANCE FOR HELPING US RUN OUR OPERATION AS SMOOTHLY AS POSSIBLE.

NAME____DATE OF BIRTH____________________

ADDRESS______________________________________SOC. SEC. #________________________

CITY, STATE, ZIP______________________________HOME PHONE______________________

PLACE OF EMPLOYMENT_____________________BUS. PHONE________________________

CELL PHONE NUMBER_______________________E-MAIL ADDRESS__________________________

ADDRESS, CITY, STATE, ZIP____

MEDICAL INFORMATION

HEIGHT_______________________________________WEIGHT________________________

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

_______HEART CONDITION
_______CANCER
_______ARTHRITIS
_______CONVULSIONS
_______PHLEBITIS
_______NIGHT SWEATS
_______RAPID WEIGHT LOSS
_______BLOOD CLOTS
_______DIABETES
_______COMPRESSED OR RUPTURED DISC
_______FATIQUE
_______STENOSIS
_______THYROID PROBLEMS
_______OSTEOPOROSIS
_______OSTEOMYELITIS
_______HIGH OR LOW BLOOD PRESSURE
_______TENDINITIS
_______HIV VIRUS OR AIDS
_______INDIGESTION

IF YES, PLEASE DESCRIBE____
____
____
____

PLEASE LIST ANY OTHER PHYSICAL CONDITIONS NOT MENTIONED ABOVE____

DO YOU WEAR CONTACT LENSES?____DENTURES/REMOVABLE BRIDGES?________

WOMEN: DO YOU WEAR AN IUD?_______ARE YOU PREGNANT?___________________

HAVE YOU HAD ANY BROKEN BONES?_______PLEASE DESCRIBE_________________

HAVE YOU HAD ANY SURGERY?_______BRIEFLY DESCRIBE______________________

WHAT MEDICATION HAVE YOU TAKEN DURING THE LAST SIX MONTHS?________

ARE YOU PRESENTLY BEING TREATED BY A MEDICAL DOCTOR?______IF YES,
BRIEFLY DESCRIBE____

NAME & ADDRESS OF PHYSICIAN____

ARE YOU PRESENTLY IN PSYCHOTHERAPY?_____________________________________

ARE YOU EXPERIENCING CHRONIC OR ACUTE DISCOMFORT? ____________________

IS THIS DISCOMFORT THE RESULT OF AN ACCIDENT? _______________IF YES,
PLEASE BRIEFLY DESCRIBE THE ACCIDENT.

WHAT WOULD YOU LIKE TO GET OUT OF ROLFING? ______________________________

WHO MAY WE THANK FOR REFERRING YOU?_____________________________________

OTHER COMMENTS____

TO THE BEST OF MY KNOWLEDGE THE ABOVE IS TRUE AND CORRECT.

SIGNATURE DATE