HEALTH QUESTIONNAIRE

Name _____ Referred by _____

Address _____ City _____ Zip _____

Phone (h) _____ (cell) _____ (w) _____

Email _____ Occupation _____

Height _____ Weight _____ Age _____

Please circle Y for Yes if you have had any of the following:

Heart Condition	Y	Thyroid Problems	Y
Cancer	Y	Diabetes	Y
Arthritis	Y	Osteoporosis or osteomyelitis	Y
Convulsions	Y	Orthopedic braces or shoes	Y
Phlebitis or hemophilia	Y	High or low blood pressure	Y
Kidney or urinary problems	Y	Dentures or removable bridge	Y
Contact lenses	Y	Hernias	Y
Allergies	Y	Pregnancy (current)	Y
Sinus problems	Y	I.U.D.	Y
Whiplash	Y	Surgical pins/plates	Y
Scoliosis	Y	TMJ syndrome	Y
Chronic or recurrent pain	Y	Cosmetic surgery	Y
Headaches/migraines	Y	Respiratory disorder	Y
Ulcer or digestive disorder	Y	Eliminatory problems	Y
Degenerative joint disease	Y	Other, explain _____	Y

Have you had any broken bones or major sprains? _____ Briefly describe: _____

_____

Any major injuries, illnesses or accidents? _____ Briefly describe: _____

_____

Have you had any surgery? _____ Briefly describe: _____

_____

Describe any chronic or recurrent pain: _____

Are there any activities from which you are restricted?_____

What medications have you taken in the past 6 months? _____

Are you presently under the care of a medical physician/chiropractor/therapist? _____

If yes, for what? _____

If not, date of last physical _____

Are you presently in psychological therapy? _____

Taiya Graham, Certified Rolfer, LMT
417 Oella Avenue, Catonsville, MD 21228 (410) 404-3485

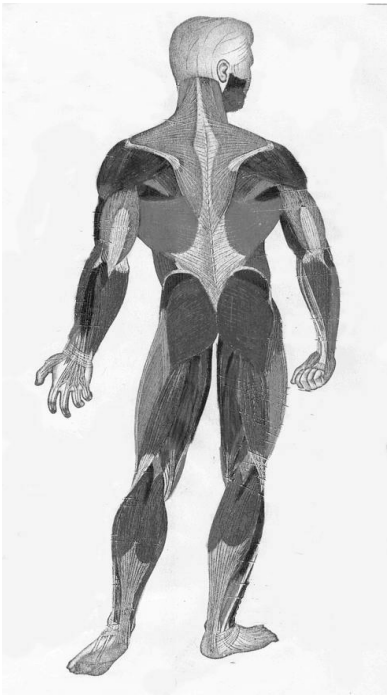
What is your current exercise program? How many hours per week?_____

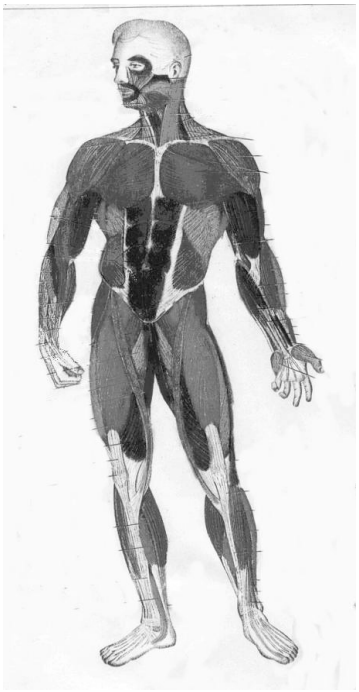
Have you had Rolfing or other bodywork in the past? _____

What do you hope to gain from Rolfing? _____

How did you find out about me? _____

Please circle and number the areas of the body that you have had injuries, accidents, surgeries, or pain. Use the table below to correspond the area on the body with the description.





	Year of incident	Description
1		
2		
3		
4		
5		
6		

CANCELLATION POLICY: *Due to the large amount of time that must be blocked out for each appointment, the full fee will be charged for missed appointments or cancellations with less than 24 hours notice.*

I certify that the above information is true and accurate to the best of my knowledge, and I agree to keep my appointments in a timely manner.

Signature _____ Date _____

Taiya Graham, Certified Rolfer, LMT
2HOODMHHDWRMLOOH0 (410) 404-3485