

Advanced Roling

Steven Radiloff, MA (Advanced Rolfer)

Health Questionnaire

| | |
|-----------------------------------|---------------------------------------|
| Name: | Phone: work: home: |
| Address: | mobile: |
| Postal Code: | Social Insurance #: (optional) |
| Email: * | Family Physician: Phone: |
| Birth Date: | Date of Last Physical Exam: |
| Height: Weight: | Occupation: |
| How did you hear about us? | Referred by: |

Health History:

| | Have | Had | Date | Describe |
|---|------|-----|------|----------|
| Arthritis (Type:) | | | | |
| Athletic Injury | | | | |
| Auto Accident | | | | |
| Back Surgery | | | | |
| Birth Defect | | | | |
| Braces (Dental or Orthopaedic?) | | | | |
| Cancer or Malignancy | | | | |
| Chemotherapy | | | | |
| Chronic Pain | | | | |
| Cosmetic Surgery | | | | |
| Degenerative Joint Disease | | | | |
| Dental Problems | | | | |
| Diabetes | | | | |
| Elective Surgery | | | | |
| Epilepsy | | | | |
| Eye/Ear/Nose/Throat Disorder | | | | |
| Fractures | | | | |
| Genito-Urinary Disorder | | | | |
| Gout | | | | |
| Haemorrhoids | | | | |
| Heart or Artery Disease | | | | |
| High Blood Pressure | | | | |
| Injuries | | | | |
| IUD | | | | |
| Low Back Pain | | | | |
| Mental or Nervous Disorders | | | | |
| Migraine Headaches | | | | |
| Miscarriages / Abortions | | | | |
| Operations | | | | |
| Orthodontic Appliances | | | | |
| Osteoporosis | | | | |
| Pregnancies | | | | |
| Prolonged Drug Therapy (i.e. Cortisone) | | | | |

* Your email address will not be shared outside the Electra Health Floor Inc. and will be used for booking purposes only (i.e. appointment confirmations and reminders).

| | | | | |
|---|--|--|--|--|
| Prostate Problems | | | | |
| Respiratory Disorder | | | | |
| Serious Disease | | | | |
| Skin Disease | | | | |
| Surgical Pins/Plates/Prosthetic Devices | | | | |
| Tension Headaches | | | | |
| TMJ Syndrome | | | | |
| Ulcer or Digestive Disorder | | | | |
| Venereal Disease | | | | |
| Whiplash Injury | | | | |

Previous Treatments:

| | Have | Had | Date | Practitioner | Phone #: |
|--------------------------|------|-----|------|--------------|----------|
| Acupuncture | | | | | |
| Biofeedback | | | | | |
| Chiropractic | | | | | |
| Homeopathy | | | | | |
| Orthopaedic | | | | | |
| Osteopathy | | | | | |
| Psychiatry | | | | | |
| Psychotherapy | | | | | |
| Other (Describe: _____) | | | | | |

Drugs & Nutrition:

| | Past | Current | Amount |
|---------------------------------|------|---------|--------|
| Alcohol | | | |
| Aspirin | | | |
| Caffeine | | | |
| Laxatives | | | |
| Non-Prescription (Type: _____) | | | |
| Prescription (Type: _____) | | | |
| Recreational (Type: _____) | | | |
| Tobacco | | | |

Are you on a special diet? (y/n) ___ Describe: _____

Do you feel your diet is adequate to maintain your health? _____

Estimate your daily caloric intake: _____

Do you take vitamins or diet supplements? _____

Activity:

Is there any activity from which you are restricted? Describe: _____

PHYSICAL ACTIVITIES YOU ARE INVOLVED IN: *Please check where applicable.*

| | Past | Current | How Often / Duration |
|-------------------------|------|---------|----------------------|
| Aerobics | | | |
| Basketball | | | |
| Bicycling | | | |
| Dance | | | |
| Exercise (Type: _____) | | | |
| Football | | | |
| Gymnastics | | | |

