



Govinda Bader, Certified Rolfer  
1990 Lombard St. San Francisco, CA 94123 415-225-9666  
6536 Telegraph Ave. Oakland, CA 94609 415-225-9666

### HEALTH QUESTIONNAIRE - PLEASE PRINT CLEARLY

Name \_\_\_\_\_ Date: \_\_\_\_\_  
Address \_\_\_\_\_ Height: \_\_\_\_\_  
\_\_\_\_\_ Weight: \_\_\_\_\_  
Phone h) \_\_\_\_\_ (c) \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Email \_\_\_\_\_ Occupation \_\_\_\_\_

**Do you have any of the following conditions? Circle (Y) for yes or (N) for no**

- |                                  |   |   |                               |   |   |
|----------------------------------|---|---|-------------------------------|---|---|
| 1. Heart Condition               | Y | N | 12. Respiratory Problems      | Y | N |
| 2. High/Low Blood Pressure       | Y | N | 13. Eliminary Problems        | Y | N |
| 3. Hemophilia (blood disorder)   | Y | N | 14. Circulatory Problems      | Y | N |
| 4. Diabetes                      | Y | N | 15. Digestive Problems        | Y | N |
| 5. Cancer                        | Y | N | 16. Contact Lenses            | Y | N |
| 6. Convulsions                   | Y | N | 17. Dentures/Removable Bridge | Y | N |
| 7. Thyroid Problems              | Y | N | 18. I.U.D.                    | Y | N |
| 8. Osteoporosis (bone mass)      | Y | N | 19. Headaches/Migraines       | Y | N |
| 9. Arthritis                     | Y | N | 20. Knocked unconscious       | Y | N |
| 10. Osteomyelitis (bone disease) | Y | N | 21. Other, explain below      | Y | N |
| 11. Phlebitis                    | Y | N | _____                         |   |   |

22. Are you presently under the care of a medical physician/chiropractor/therapist? Y N  
If yes, for what? \_\_\_\_\_

23. What medications have you taken in the past 6 months? \_\_\_\_\_

24. Do you have any chronic bodily discomfort? If so, where? \_\_\_\_\_  
\_\_\_\_\_

25. Does anything make it better or worse? \_\_\_\_\_  
\_\_\_\_\_

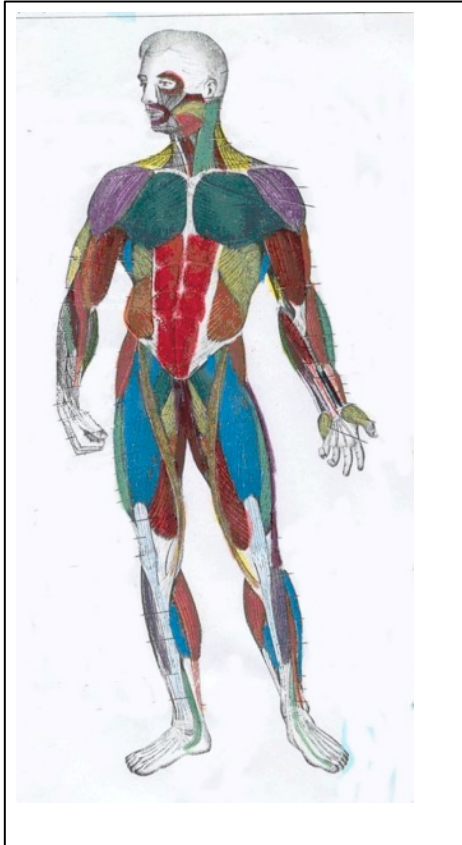
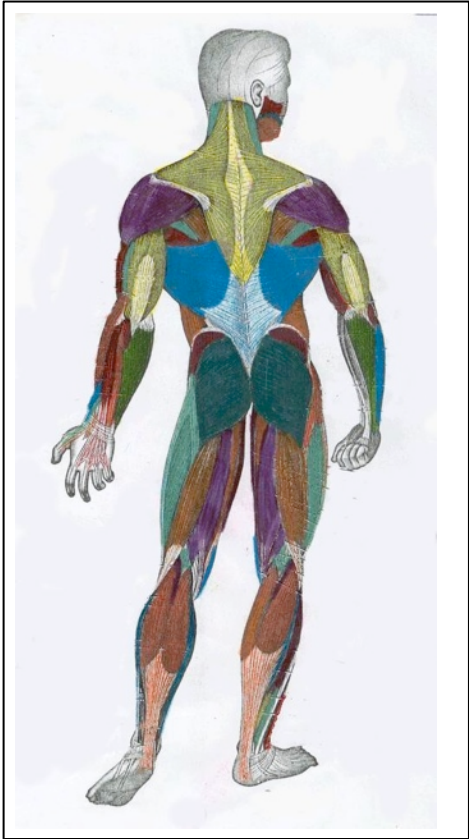
26. What is your current health/stretching/exercise routine? \_\_\_\_\_  
\_\_\_\_\_

27. What is your previous bodywork/massage/Rolfing® experience? \_\_\_\_\_  
\_\_\_\_\_

28. What do you hope to gain from working with Govinda? \_\_\_\_\_

29. How did you find out about Govinda? \_\_\_\_\_

Please circle and number the areas of the body that you have or had pain, tension, injuries or surgeries:



Please describe areas numbered above:

No	Year	Description
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

I certify that the above information is true and accurate to the best of my knowledge. If I experience any pain or discomfort during my treatment, I will immediately inform Govinda so my treatment can be adjusted to my comfort level. I further understand that my treatments are not to be construed as a substitute for medical treatment, examination or diagnosis and that I should see a physician or other medical specialist for any mental or physical ailments that I may have. By signing this document, I acknowledge that I have been informed and fully understand and accept responsibility for my health and any injury or mishap that may affect my well-being or health in any way.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Client or Guardian if under 18 yr. of age

\_\_\_\_\_  
Date