Elisabeth Berg Harris
Certified Rolfer™
720-490-9000

Thank you for taking the time to fill out this confidential questionnaire.

Personal Information

Date: _____

(Please Print)

Name: _____

Phone: (_____)_____ **E-Mail**:_____

Address: _____

City: _____ **State**: _____ **Zip**: _____ **Date of Birth:** _____

Occupation: _____

Emergency Contact:_____ **Phone:** (____)_____

Relationship:_____

Referred by:_____

Have you been Rolfed before? Y / N
Medical Physician / Phone: _____

What treatments have you received previously?

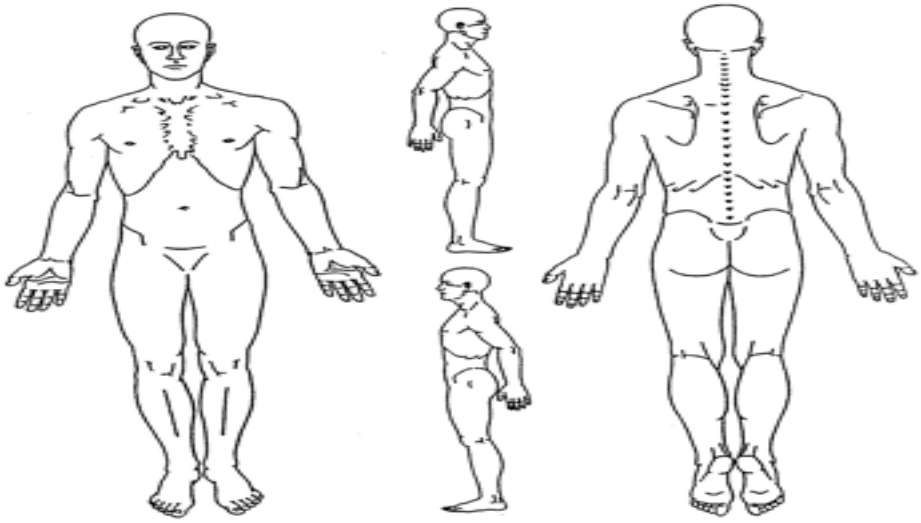
Massage - Physical Therapy - Surgery
Acupuncture - Chiropractic - Medication - Other__

List any surgeries: _____
List any medications; _____
List any current symptoms/pains and when they occurred:
_____
How often do you have this symptoms/pains?_____
Is it constant or does it come and go? _____
What makes it better? _____
What makes it worse? _____

Please indicate if you have any of the following:

Low Back Pain	Mentally Restless	Herniated Disks	Elbow Pain	Low Energy
Pinched Nerve	Difficulty Sleeping	Hi/Low BP	General Fatigue	Digestive Problems
Sciatic Pain	Knee Problems	Lack of Appetite	Muscle Fatigue	Unstable / Weak Muscles
Muscle Spasms	Constipation	TMJ	Dizziness	Allergies
Arthritis	Get sick often	Shortness of Breath	Headaches	Easily Angered / Agitated
Headaches	Neck pain	Chest pain		AIDS / HIV / OTHER

Please mark your areas of pain:



If you could change/improve 3 things in regard to your body, what would they be?

_____

_____

_____

Disclaimer

I understand that Rolfers do not diagnose illness, disease or any other physical or mental disorder; nor do they prescribe medical treatment of any kind. I acknowledge that Rolfing Structural Integration is not a substitute for medical examination, diagnosis or treatment, and that it is recommended that I see a physician for these services.

Fees are as follows:

Rolfing Session: ***$ 120.00***
(90 minutes)

Payment Policy

I, the undersigned, understand and agree to the payment policy. I acknowledge that payment for all care received is my responsibility. Payment is due at time of service unless other arrangements have been made in advance. I accept cash or checks and VISA or MC. **I also understand that a 24-hour cancellation notice is necessary to avoid charges.**

Cancellation Agreement

A full fee $ 120.00 will be charged for missed appointments. Cancellations without 24 hours notification will be charged $ 60.00. I have read, understand, and agree to the cancellation agreement.

_____ _____
Signature Date