Rossiter System Health History Addendum

Name :____Date of Birth:_______________Date : ______________
How did you hear about Rossiter? ____
Do you currently receive other body work? Yes No
If Yes, list type: ____
Name and type of medical providers you are currently under the care of : _____________________________
____
Are you currently under exercise or activity restrictions by your Dr.? Yes No
If Yes, explain restrictions: ____
____
Current activity level - Sedintary Stand most of the day Computer Work Variety of Activities
Regular Exercise Regime Extremely Active/Athletic
Can you safely get up and down on the floor without assistance? Yes No.
Do you smoke? Yes No. How many a day: _______________________________________
List how many hours per night & what side of the body do you primarily sleep on? ______________________
____
Check (X) all current or past medical conditions.

Epilepsy	Pace Maker	Pregnant or may be pregnant	Stroke
Dizziness/Vertigo	High Blood Pressure	Low Blood Pressure	Scoliosis
Fibromyalgia	Asthma	PTSD	Neuropathy
Neurological Disorder	Rheumatoid Arthritis	Autoimmune Disease (List): ______________	
Osteoarthritis	Varicose Veins	Artificial Joints (List): ______________	
Blood Clots	Heart Problems	Postural Deformities (List):______________	
Breast Implants	Thyroid Disease	Steroid Inhalers	

Neurological Disorder (list) ________________________ Diabetes-how long? ______________________
Insulin injection Osteoporosis (List meds): ____
Drug patches (List Kind/Location) : ________________ How long had it? ______________________
Surgery in last 6 months? (List) ____
Back surgery or injections to back-ever? (List) ____
Cortisone Injections EVER? List body part and when? ____
Do you have any pins, plates, screws or schrapnel in your? (List Specifically) ____________________________
Do you currently have any rashes, open sores, shingles, skin eruptions? (List)_____________________________
Any other medical problems/diagnosis not listed above? (List)______________________________________
Muscle relaxers or pain medications you take on a regular basis-even over-the-counter. List when your last dose was.
____
Other medications-prescribed or otherwise____
Have you ever taken Quinolone, Levaquin, Cipro? List :____
Recent Injury. (List): ________________________ Cancer. List: ______________________________

- Stress Level at Home + | - Stress Level at Work +
1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10

By signing this form, I confirm I have read & fully understand all the contents and I have answered every question completely and accurately. If I have any changes in medical history, I will inform my Rossiter Coach prior to next Rossiter session.

Signature :____Date : ______________________