Today's Date: _____

Updated: _____

Updated: _____

Updated: _____

Health History

Client's Name: _____

Occupation: _____

Physician's Name: _____ Phone Number: _____ City: _____

May we contact your Physician? ○ No ○ Yes

Medical Conditions: On the following chart, please mark all conditions you experience and **any medication** prescribed for it.

RESPIRATORY

- ○ Chronic Cough
- ○ Shortness of Breath
- ○ Bronchitis
- ○ Asthma
- ○ Emphysema
- ○ Other_____

CARDIOVASCULAR

- ○ Blood Pressure ○ High ○ Low
- ○ Heart Attack/Cong Heart Failure
- ○ Angina / Atherosclerosis
- ○ Phlebitis
- ○ Stroke – CVA
- ○ Pacemaker
- ○ Varicose Veins
- ○ Other_____

SKIN

- ○ Open wound
- ○ Eczema
- ○ Skin allergy
- ○ Loss of Sensation
- ○ Other_____

SOFT TISSUE AND JOINT DYSFUNCTION

- ○ Neck pain or stiffness
- ○ Low Back pain or stiffness
- ○ Shoulder pain or stiffness
- ○ Arms pain or stiffness
- ○ Leg pain or stiffness
- ○ Internal pins, screws, or wires
- ○ Artificial joint
- ○ Other_____

OTHER CONDITIONS

- ○ Loss of Sensation
- ○ Diabetes ○ type 1 ○ type 2
  onset _____
- ○ Allergies
- ○ Epilepsy
- ○ Cancer
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis
- ○ Digestive Concerns
- ○ Other_____

HEAD AND NECK

- ○ Vision Problems
- ○ Vision Loss
- ○ Ear Problems
- ○ Hearing Loss
- ○ Other_____

INFECTION

- ○ Hepatitis
- ○ Skin Condition
- ○ TB
- ○ HIV
- ○ Other_____

CONDITION OF SPINE

- ○ Scoliosis
- ○ Kyphosis
- ○ Degenerative Disc Disease
- ○ Other_____

WOMEN

- ○ Pregnancy, due date _____
- ○ PMS

List any other medication: _____

Injury and Surgery: List all surgeries and severe injuries. Include car accidents, fractures, dislocations, sprain, whiplash, etc.

Date: _____ Details: _____

_____

Date: _____ Details: _____

_____

Date: _____ Details: _____

_____

Date: _____ Details: _____

_____

Over →

Complete the following information to help us understand your expectations for the care <u>you want</u> to receive.

1. What type of care are you interested in receiving?

◯	Occasional relaxation treatments only. If yes, continue to **Consent to Treatment** .
◯	Care for a specific complaint. Describe:

2. How much does this complaint affect the following aspects of your daily life?

Physical activity	◯ Occasionally	◯ Daily by 25%	◯ Daily by 50%	◯ Daily by 75%	◯ Daily by 100%
Sense of well-being	◯ Occasionally	◯ Daily by 25%	◯ Daily by 50%	◯ Daily by 75%	◯ Daily by 100%
Stress level	◯ Occasionally	◯ Daily by 25%	◯ Daily by 50%	◯ Daily by 75%	◯ Daily by 100%
Work activity	◯ Occasionally	◯ Daily by 25%	◯ Daily by 50%	◯ Daily by 75%	◯ Daily by 100%

3. What statement best describes how <u>you want</u> to approach treatment?

◯	At this time I am not able to deal with a specific problem, however I would like some temporary relief.
◯	I want relief of the symptoms I am currently experiencing.
◯	I want to manage this problem so that I can keep on top of it.
◯	I want to resolve this problem.
◯	I want to resolve this problem and then prevent it from recurring.

4. What other therapy have you received for this complaint? Describe outcome of therapy.

☐ Massage Therapy	☐ Chiropractic	☐ Physiotherapy	☐ Other

5. What forms of exercise do you do ? _____

   How often? _____

<u>Consent to Treatment</u>

- It is important that your needs are communicated at the beginning of each session, and as your needs change, your treatment will change. The specifics of each treatment, its benefits, side effects and alternative treatments will be discussed with you during each visit. At all times, you have the right to alter the treatment you have discussed with the therapist, including withdrawing your consent. If you have any questions or concerns, please communicate them to the therapist.

<u>Policy Statements</u>

- Massage Therapists and other professionals working at The Stress Shop provide assessments but cannot provide you with a medical diagnosis. You will be referred to your family physician for this purpose.
- All professionals working at The Stress Shop are self-employed independent contractors and not employees of The Stress Shop. I consent to have my clinical notes and records kept by The Stress Shop and authorize the treating therapist to furnish The Stress Shop with this information
- Your health history and treatment notes will be kept at The Stress Shop for 10 years after your last treatment date. This information is kept confidential and will only be viewed by the therapist(s) responsible for your treatment.

I acknowledge that I have read the Consent to Treatment and Policy Statements. I certify that the information I have provided on this form is accurate to the best of my knowledge.

Client Signature: _____