Fountain of Health CHIROPRACTIC and Massage

Consultation Admittance Form - Massage

Last Name: _____ First Name: _____

Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

How do you prefer to be contacted: □home phone □cell phone □work phone □email

Number at which a message can be left: □home phone □cell phone □work phone

Age: ____ Birth Date (m/d/y): _____ Sex: M/F Height: _____ Weight: _____

Occupation: _____ Pregnant □Yes □No Due date: _____

Emergency Contact Name: _____ Phone: _____

Physician's name: _____

Chiropractor's name: _____

May I share the results of your examination and treatment plan with Dr. Raiwet? □Yes □No Initial _____

How did you hear about us? □ad □sign □referral by whom: _____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE.

Have you had a massage before? □Yes □No □ Therapeutic □ Relaxation How long ago? _____

Reason for this appointment: _____

Are you presently taking any medications? □Yes □No Please List: _____

Have you had any previous injuries, illnesses, disease or accidents? _____

#107 - 20 Northlands Way NE ⁞ Medicine Hat, AB ⁞ T1C 1Z2 ⁞ phone (403)529-5972 ⁞ fax (403)529-5973

Fountain of Health CHIROPRACTIC and Massage

Name: _____

Health Status Survey – Please check (√)any conditions or symptoms presently causing you problems or have been a problem to you in the past.

Present	Past		Present	Past		Present	Past	
_	_	Arthritis	_	_	Low Blood Pressure	_	_	TMJ
_	_	Cancer	_	_	Diabetes	_	_	Varicose Veins
_	_	Sciatica	_	_	Heart Disease	_	_	Haemophilia
_	_	Fibromyalgia	_	_	Seizures	_	_	Sprains/Strains
_	_	Migraines	_	_	Epilepsy			Where:_____
_	_	Neck Pain	_	_	Headaches	_	_	Anxiety/Depression
_	_	Muscle Tension	_	_	Tendonitis	_	_	Thyroid Problems
_	_	Tingling/numbness	_	_	Back Pain	_	_	Bruise Easily
_	_	Where:_____	_	_	Asthma	_	_	Insomnia
_	_	High Blood Pressure						

Other: _____

_____

Allergies: _____

_____

Are there any other medical conditions I should be aware of? _____

_____

How many glasses of water do you drink in a day? _____

How many caffeinated beverages do you drink in a day? _____

How many alcoholic beverages do you drink in a week? _____

Are you a smoker? □Yes □No

Do you have regular eating habits? □Yes □No

Do you participate in a regular exercise program? □Yes □No

Are you sleeping well? □Yes □No

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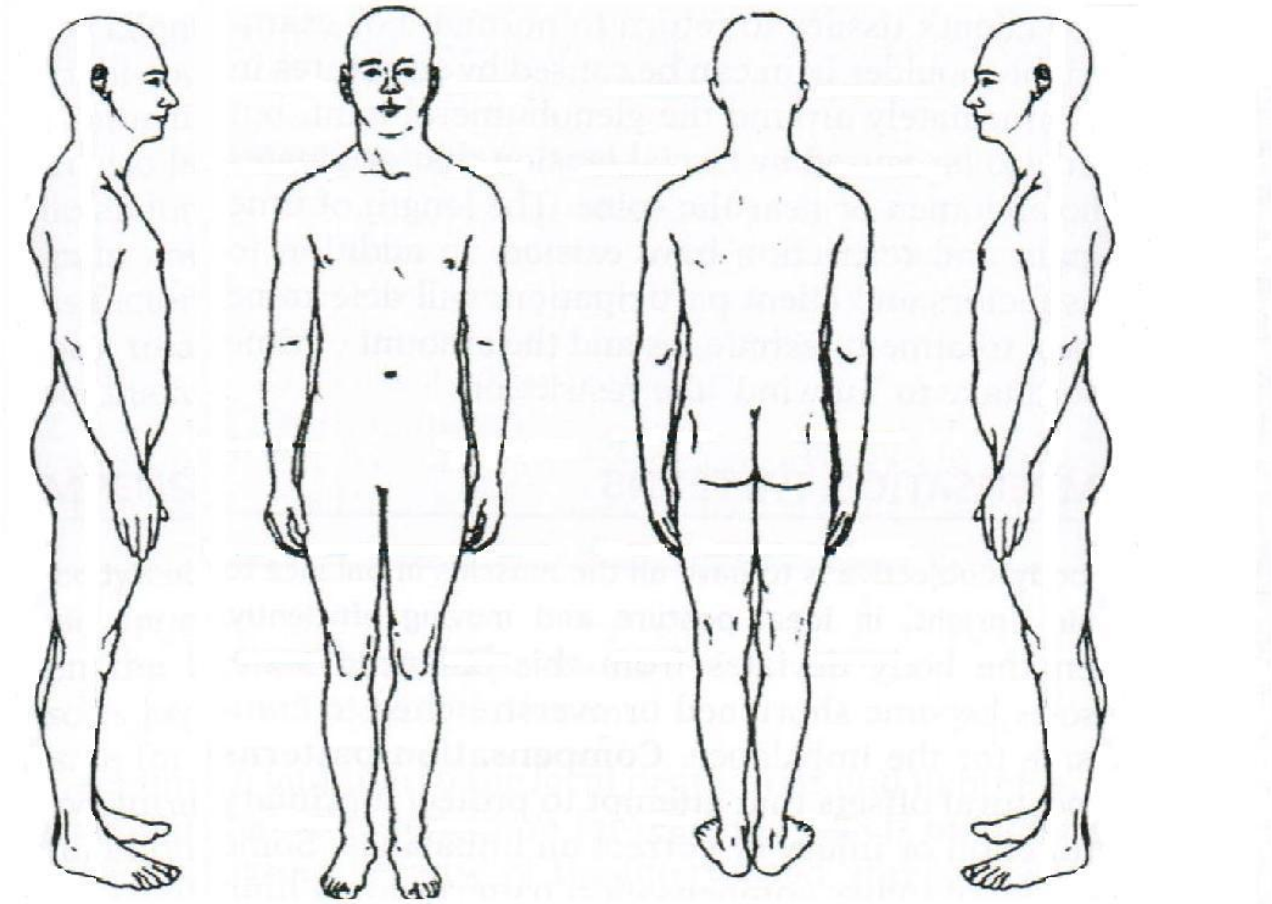
Name: _____

In the diagrams provided below, please mark the areas on your body which you feel best represents the pain or discomfort. Please include *all* areas.



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Name: _____

Massage Therapy Waiver

I understand that the massage I receive is provided for the basic purpose of relaxation, stress reduction and relief of muscular tension. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical professional for any other physical ailments that I am aware of.

I understand that massage therapists are not qualified to perform skeletal adjustments, diagnosis and/or prescribe, and that nothing said in the course of the session should be construed as such.

Because massage is contraindicated under certain conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile, and understand that there shall be no liability on the therapist's part should I forget to do so.

It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment for the full scheduled appointment.

I am aware and understand I will be required to disrobe in order to receive massage therapy.

Signed: _____ Date: _____

LaStone Therapy (this section to be signed only if receiving LaStone Therapy)

I am aware of the extreme temperatures used in this treatment and hereby consent to assume all responsibility to communicate the slightest bit of discomfort or pain, releasing any and all liability of the LaStone Therapist.

Signed: _____ Date: _____

Cancellation Policy – Applicable to both Massage Therapy and LaStone Therapy

NO SHOWS and Cancellations with less than 12 hours notice will be assessed the full fees of the missed appointment. If I am unable to make my appointment, I will try to fill the space with someone else or I understand I will be charged.

Signed: _____ Date: _____

All client information is confidential and under no circumstances will any personal information be released to anyone without written consent.

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