Statera Therapies

Confidential Health History

All answers given will aid in receiving the best possible treatment. Please fill out as honest and as in depth as you can. All information is considered confidential.

Name:______________________________ Birth: D____/ M____/ Y_____ Age:__________
(first) (last)

Address:____________________________ City:________________ Postal Code:__________

Phone Number: Cell:______________ Work:________________ Home:________________

Email:______________________________ Occupation:______________________________

Sex (circle): M F Height:____________________ Weight:____________________

Emergency Contact Name:_________________________ Phone Number:________________

Medical Doctor:________________________ Referred By:___________________________

Do you currently have an SGI (motor vehicle accident) or WCB (work injury) claim? Yes or No (circle one)

What is your reason for consulting this office?___________________________________

How long have you had this condition for?_______________________________________

What is this problem preventing you from doing?__________________________________

What have you tried that has not worked?____

Have you had any test performed (X-ray, lab work i.e blood/urine)? Yes_____ No_____
(if so) When?________________ Where?__________________ Why?________________

Have you had any work or car injuries within the past year?_____ 5 years?_____Over 5 years?_____
Please describe:____

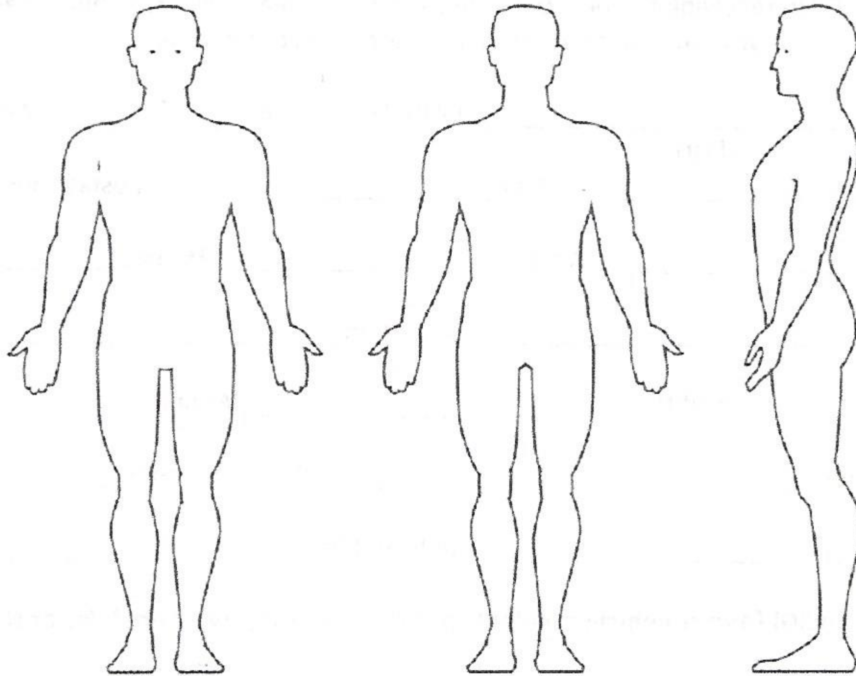
Do you sleep well? Yes_____ No_____ Preferred Sleep Position:____________ Restless? Yes_____ No_____

Are you currently on any medications or supplements (including Tylenol, Advil or Vitamins)?
Yes____ No____ Please list:____

Are you pregnant? No_____ Yes____ Due Date:______________
Any serious illnesses? Yes____ No____ Please describe:_____________________________
Any skin conditions? Yes____ No____ Please describe:______________________________
Any major surgeries? Yes____ No____ Please describe:______________________________

Have you recently had any problems with the following: (please circle)

Dizziness	Sinus Trouble	High or Low Blood Pressure	Depression/Anxiety	Epilepsy
Neck Pain	Asthma	Strokes	Bowel/Bladder/Menstrual	Cancer
Back Pain	Diabetes	HIV	Digestive Disorders	**None of the above**
Head Aches	Arthritis	Heart Trouble	Other:________________	



Please label on the diagram where you feel any pain or discomfort

Please rate your pain level on the line below

no pain ____ **pain as bad as it could be**

1 2 3 4 5 6 7 8 9 10

Personal Habits:

Alcohol Servings/Week	7+____	4-6____	1-3____	0____
Coffee/Tea/Soft Drinks/Day	4-5____	2-3____	1____	0____
Tobacco/Day (packages)	1____	¾____	½____	0____
Exercise/Week	4-7____	3____	1-2____	0____

Types of exercise/activities:____

________________________________ ________________________________

Patient Signature Date

Statera Therapies
Unit B 924 Northumberland Avenue
Saskatoon, Sk S7L3W8

Please note: your appointment time is specifically reserved for you. Failure to give a minimum of 3 hours notice to cancel this appointment will result in a cancellation fee. Failure to show up to this appointment will result in a "no show" fee. This applies to WCB and SGI treatments as well, which will be at the client's expense.

Cancellation fees are as follows:
$10.00 less than the regular treatment price.

____
Signature

Thank you for your co-operation and understanding!

Informed Consent to Massage Therapy Treatment

I understand that the Massage Therapist is providing massage therapy services within their scope of practice as defined by the Massage Therapist's Association of Saskatchewan, Inc and Natural Health Care Practitioners of Canada. I understand this is a professional treatment space and no further "services" or intent will be tolerated.

I hereby consent to my therapist to treat me with massage therapy for the above-noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above-noted consent and I have had the opportunity to question the contents of my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment proposed by my therapist from time to time to deal with my physical condition and for which I have sought treatment. I understand that at any time, I may withdraw my consent and treatment will be stopped. This applies to the therapist as well.

__________________________	__________________________
Print Name	Witness
__________________________	__________________________
Signature of Client/Guardian	Date