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.

Full Name:	**Date of Birth: D___ /M____ /Y_____**	**Age: Height: Weight:**
Address:	**City/Town:**	**Postal Code:**
Occupation:	**(circle): Female Male Other**	**Email:**
Cell Number:	**Home Number:**	**Medical Doctor:**
Emergency Contact:	**Contact's Number:**	**Referred by:**

Do you currently have an SGI (motor vehicle accident) **or WCB** (work injury) **claim? Yes or No** (circle one)
If yes, claim number?: _____

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 tests performed (X-ray, lab work i.e blood/urine, CT, MRI)? No_____ Yes_____
(if yes) 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 prescribed, non-prescribed medications, or supplements (including Tylenol, Advil or Vitamins)?
No____ Yes____ Please list:_____

Are you pregnant? No ____ Yes ____ Due Date:_____
Any serious illnesses? No ____ Yes ____ Please describe:_____
Any skin conditions? No ____ Yes ____ Please describe:_____
Any major surgeries? No ____ Yes ____ Please describe:_____
Any hardware (pins, screws, plates ect.)? No ___ Yes ____ Please describe:_____

Personal Habits:

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

Types of exercise/activities:_____
_____

Do you presently have any problems with the following: (please check all that apply)

Muscle & Joints:
□ Joint Pain
□ Arthritis
□ Neck pain
□ Back pain
□ Joint Replacement
□ Sprain/Strain/Fracture

Gastrointestinal/Urinary:
□ Gas/bloating
□ Ulcers
□ Bladder infection/Kidney
□ Digestive/Bowel disorders
□ Constipation/diarrhea
□ Bladder infection/Kidney

Neurological:
□ Dizziness
□ Head aches
□ Epilepsy/Seizures
□ Concussion
□ Numbness/ tingling

Respiratory:
□ Asthma
□ Sinus trouble
□ COPD
□ Emphysema

Cardiovascular:
□ High blood pressure
□ Low blood pressure
□ Stroke
□ Heart disease
□ Varicose viens
□ Blood clots

Reproductive:
□ Prostate issues
□ Breast lumps
□ Menstrual issues
□ Menopausal symptoms
□ Cysts

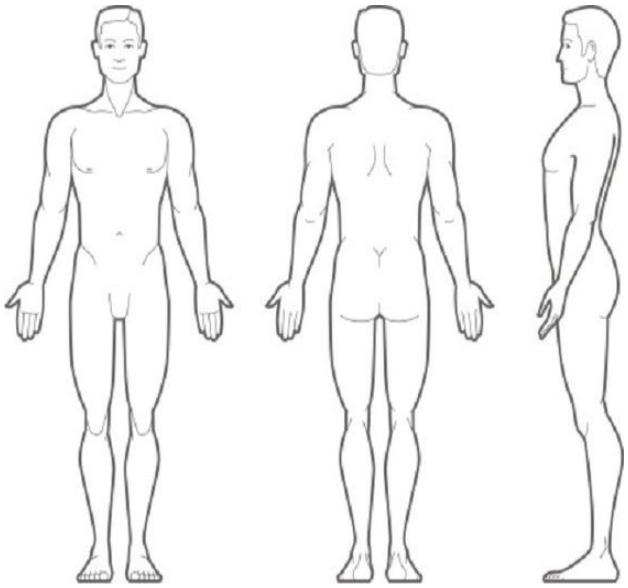
Other:
□ AIDS, HIV other STI
□ Cancer
□ Depression/Anxiety
□ Diabetes
□ Thyroid

Others Not Listed:_____

_____

Family History Of Any Above:_____

_____



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

Client Signature:_____ Date:_____

Statera Therapies
Unit 40 2712 Wentz Avenue
Saskatoon, Sk S7K 5S2

Please note: your appointment time is specifically reserved for you. Failure to give a minimum of 12 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