CONSENT AND CONFIDENTIAL CASE HISTORY

File Number:

For your information:

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let us know. All information gathered for this treatment is confidential except as required by law or except to facilitate assessment or treatment. You will be asked to provide written authorization for release of any information

Insurance Number:

CONTACT INFORMATION

Last Name	First Name	Date of Birth (mm/dd/yyyy}	Male☐ Female☐
Address		City	Postal Code
Email Address		Cell	Phone
Family Doctor	Family Doctor Phone	Chiropractor/Physiotherapist	Phone

Has it been more than 6 months since your last massage? Yes☐ No☐	Name your favourite parts of a massage? (your back, shoulders, feet)	Are there areas you dislike being massaged or do not want to be massaged? (feet, face)
Are you Pregnant Yes☐ No☐	If yes how many weeks	Do you Smoke Yes☐ No☐

Please list any major surgeries:

Any Allergies to Oils, lotions or powder, Skin conditions or reaction to lotion or creams

Have you ever been in a car accident? Yes ☐ No☐, if yes, when?

Primary Reason For Your Appointment:

PLEASE NOTE THAT 24 HOURS NOTICE IS REQUIRED FOR THE CANCELLATION OF AN APPOINTMENT. IF YOU ARE SICK, OR ARE OTHERWISE UNABLE TO ATTEND FOR YOUR ALLOTTED TIME, PLEASE CALL TO MAKE OTHER ARRANGEMENTS.

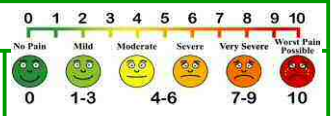
CONSENT AND RELEASE: I have read and thoroughly understand all of the above form. The information given is correct and complete to my knowledge. I shall notify the therapist upon any changes or updates of my health or medication so my file information remains current. I have the right to consent to all or part of the session, or to withdraw consent at any time. If the description of the session beforehand is incomplete, I have the right to ask questions at any time and have them adequately answered. I will communicate information (such as pain/discomfort levels) throughout the session to ensure my own safety and the effectiveness of the session. I understand Massage Therapists at Pivotal Body Balance are not qualified to diagnose illness, disease or any other physical or mental disorder and cannot prescribe medical treatment. I assume all risks and perils to my person physically, physiologically or psychologically which may ensue during this or subsequent treatments. As well as any effects deemed detrimental which may ensue afterwards as a result of this or subsequent treatments? Pivotal Body Balance Massage Therapist's mandate is to provide you with a massage to relax the tissue increase the flow of blood and oxygen and decrease pain, of course release any stress. We will send an email reminder for your next appointment.

I fully understand and agree to the above disclaimer in this Consent Form and the conditions of receiving treatment, and what is expected of me.

Signature: _____Date: (M/D/Y)_____

Client History

Have you ever been in a car accident?	Yes ☐ No☐	If yes, when?	
Use the body picture to indicate location of injury		Do you still have pain from that injury Yes ☐ No☐	
Can you Explain the pain			
What brings the pain on			
How long does it last			
How did it happen			
Intensity of Pain on a scale from 1 to 10, (1 is no pain 9 you need to be in hospital) what is your pain level today			
Character of Pain (stinging, burning, shooting, dull)			
Frequency of Pain (all the time, certain times)			
What makes the Pain worse?			
What Relieves the Pain?			
What Treatments are being used			
List the Medications you are taking			



Diabetes? Yes☐ No☐, if yes how is it controlled ☐Diet ☐Insulin ☐Oral Medication ☐Uncontrolled

Heart Problems? ☐Chest Discomfort ☐Chest Pressure Pain ☐Heart Disease

Blood Pressure? ☐Yes ☐No, if yes how is it controlled ☐Medication ☐Uncontrolled

Respiratory/Breathing Problems? ☐Yes ☐No ☐Asthma ☐Allergies ☐Bronchitis ☐COPD ☐Emphysema

Arthritis? ☐Yes ☐No if yes ☐Rheumatoid (Autoimmune disorder) ☐Osteoarthritis ☐Osteoporosis

Which joints are affected		
Varicose Veins ☐Yes ☐No if yes, where are they located		
Tingling, numbness in ☐Arms ☐Hands ☐Chest ☐Face ☐Feet		
Do you get Headaches ☐Yes ☐No ☐Tension ☐Migraines with/without aura ☐Cluster How often:		
Received Cortisone Injections ☐Yes ☐No if so where		Date:
Have you been treated for cancer ☐Yes ☐No	Type	Date:
What is your outcome expectation/goal of treatment?		

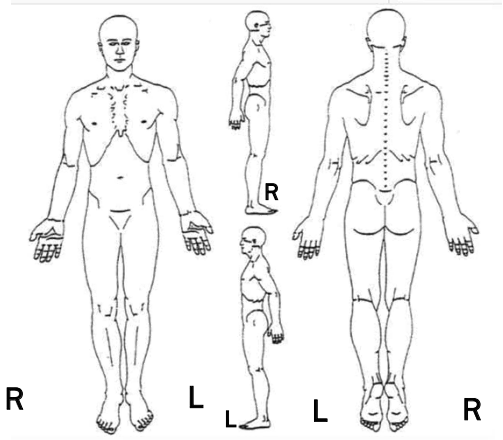
Concerns about your sleep pattern, appetite or current level of stress? ☐Yes ☐No Please describe briefly:

CURRENT HISTORY

Dominant side
Right ○ Left ○

Please use the body picture to the left to indicate the area(s) which is/are currently problematic to you.

✘ Adhesion	≈ Spasm
Rotation	Inflammation
Pain	Trigger point
• Tender Point	/ Elevation
≡ Hypertonicity	



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