SATORI Health & Wellness

# CLIENT HEALTH HISTORY AND CONSENT FORM

Name _____ Birth date (dd/mm/yyyy) _____ Age _____

Address _____ Occupation _____

City _____ Province _____ Postal Code _____

Tel (home) _____ (work) _____ (mobile) _____

E-Mail _____ Primary Complaint _____

Height _____ Weight _____ Blood pressure _____ Resting pulse _____

Have you ever received massage therapy before? _____ When was your last treatment? _____

Please list any allergies: _____

Please list presence of any internal pins, wires, artificial joints or special equipment: _____

How did you hear about us? ☐ Signage ☐ Word of mouth

☐ Website ☐ Other (specify) _____

PLEASE COMPLETE THE SECTION BELOW BY PLACING AN "X" IN THE APPROPRIATE BOXES

## CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart attack/M.I.
- ☐ Phlebitis/varicose veins
- ☐ Stroke/C.V.A.
- ☐ Heart disease
- ☐ Chronic congestive heart failure
- ☐ Pacemaker or similar device
- ☐ Family history of any of the above

## OTHER CONDITIONS

- ☐ Diabetes (onset:_____ )
- ☐ Cancer (year/location:_____ )
- ☐ Haemophilia
- ☐ Difficult digestion
- ☐ Constipation
- ☐ Liver issues:
- ☐ Gallbladder
- ☐ Urinary disorder
- ☐ Hypoglycaemia
- ☐ Epilepsy
- ☐ Hernia
- ☐ Insomnia
- ☐ Fibromyalgia
- ☐ Cystic fibrosis
- ☐ Sinus problems
- ☐ Osteoporosis
- ☐ Mental illness
- ☐ Arthritis
- ☐ Family history of any of the above

## WOMEN

- ☐ Endometriosis
- ☐ Menopause
- ☐ Menstruating
- ☐ Pregnant (due: _____ )
- ☐ Cesarean section (year: )
- ☐ Number of pregnancies:

How many were successful?

Gynecological condition:

## HEAD/NECK

- ☐ Vision problems/loss
- ☐ Hearing problems/loss
- ☐ Ear problems
- ☐ Concussion (date:_____ )
- ☐ Headaches (type: _____ )

(location:_____ )

- ☐ Migraines
- ☐ Family history of headaches/migraines

## RESPIRATORY

- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Family history of any of the above

## ALLERGIES

- ☐ Anaphylactic shock
- ☐ Nuts
- ☐ Food:
- ☐ Drug:
- ☐ Other:

## SOFT TISSUE/JOINT DISCOMFORT AND ITS NATURE

- ☐ Neck
- ☐ Shoulders
- ☐ Arms (R / L)
- ☐ Upper Back
- ☐ Mid Back
- ☐ Low Back
- ☐ Legs (R / L)
- ☐ Knees
- ☐ Other:

## INFECTIONS

- ☐ Hepatitis
- ☐ Herpes
- ☐ HIV/AIDS
- ☐ TB
- ☐ Plantar warts
- ☐ STI:
- ☐ Infectious skin disease:

## LIFESTYLE

- ☐ Smoking
- ☐ Alcohol ( daily / social )
- ☐ Regular exercise
- ☐ Vegetarian
- ☐ Coffee/tea ( 1-3cups/day 4+cups/day )
- ☐ Meditation/relaxation

## SKIN

- ☐ Sensitive/bruise easily
- ☐ Skin conditions
- ☐ Loss of sensation
- ☐ Scars
- ☐ Other: _____

Current Medications and conditions they treat:_____

_____

_____

_____

Surgery: _____ Date: _____

Injury: _____ Date: _____

Primary Care Physician: _____

Address: _____

Phone: _____

Are you presently involved in other healthcare? ☐ Yes ☐ No

If yes, please specify: _____

_____

What is your general health status? _____

*Consent re: Personal Information and Treatment*

We value the trust you have placed in us and are taking all appropriate measures to safeguard your personal information and confidence. We have established a privacy policy to ensure that your personal information and personal health information is protected. Our privacy policy is available at our reception and at *www.satoriwellness.com*. In accordance with our privacy policy, we request that you provide your consent as set out below.

I agree that Satori Health & Wellness can collect, use and disclose my personal information and personal health information provided by me in this client health inquiry history form to provide me with the services I request and for the other limited purposes set out in Satori Health & Wellness' privacy policy.

I hereby give my consent for treatment. I am also aware that Satori Health & Wellness will bear no responsibility in the event of any injury or harm that may occur as a result of treatment reasonably and professionally administered. I acknowledge that Satori Health & Wellness will not be responsible for any lost or stolen personal belongings.

I declare I will inform Satori Health & Wellness if there are any changes in my health history, upon my next visit.

**I have been advised of Satori Health & Wellness' 24hr cancellation policy, and I authorize a full service charge should this be enforced.**

Date: _____ Signature: _____ Intake Practitioner _____

Updated: _____

I wish to receive information about special events and updates from Satori Health & Wellness ☐ Yes ☐ No