Confidential patient case history form

Date _____

Name _____ ☐ Male ☐ Female

Address _____ City _____ Prov. _____

Postal code _____ Home phone _____ Work Phone: _____

Birth Date: _____(m) _____(d) _____(Y) Occupation: _____

Medical Doctor _____ Doctor Phone # _____

Referred by: _____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart attack
- ☐ Phlebitis/varicose veins
- ☐ Stroke/CVA
- ☐ Pacemaker or similar device
- ☐ Heart disease
- ☐ Dizziness/vertigo
- ☐ Seizures

Is there a family history of any of the above? ☐ Yes ☐ No

Head and Neck
- ☐ History of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Vision loss
- ☐ Ear problems
- ☐ Hearing loss

Women
- ☐ Pregnancy
  Due Date: _____
- ☐ Previous pregnancy complications _____
- ☐ Menopausal problems _____
- ☐ Menstrual problems _____
- ☐ Gynecological conditions
  Describe _____

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic cough
- ☐ Shortness of breath

Is there a family history of any of the above? ☐ Yes ☐

Muscle/joint
- ☐ Neck
- ☐ Back (lower)
- ☐ Back (mid)
- ☐ Back (upper)
- ☐ Shoulders
- ☐ Elbow
- ☐ Wrist/Hand
- ☐ Hip
- ☐ Knee
- ☐ Ankle/foot
- ☐ Spine

Infectious Conditions
- ☐ Skin Conditions
  Describe: _____
- ☐ Respiratory Conditions
  Describe: _____
- ☐ Hepatitis

Skin Conditions
- ☐ Eczema ☐ Warts
- ☐ Psoriasis ☐ Open Sores
- ☐ Rash

Digestive
- ☐ Constipation
- ☐ Chrones Disease
- ☐ Colitis
- ☐ Irritable Bowel Syndrome
- ☐ Ulcers

Other
- ☐ Lost of sensation
  Where? _____
- ☐ Diabetes
  Onset: _____
  Type _____
- ☐ Allergies/hypersensitivity
- ☐ What? _____
- ☐ Epilepsy
- ☐ Cancer
  Type/location: _____
- ☐ Arthritis
  Is there a family history of Arthritis? ☐ Yes ☐ No
- ☐ Hemophilia
- ☐ Fibromyalgia
- ☐ Chronic fatigue
- ☐ Scoliosis
- ☐ Polio/post polio
- ☐ Osteoporosis

Men
- ☐ Enlarge Prostate
- ☐ Other _____

Do you have any medical conditions not listed above? ☐Yes ☐No
If yes, please describe: _____

Do you have any internal wires, artificial joints, pacemakers or special equipment that we should be aware of? ☐Yes ☐No _____

Please circle areas which are currently causing you symptoms of pain, stiffness, numbness or other forms of discomfort

Face	Upper back	Arm(s)	Hand(s)	Thigh(s)	Ankle(s)	Neck
Mid back	Elbow(s)	Finger(s)	Knee(s)	Feet	Shoulder(	Lower back
Wrist(s)	Hip(s)	Leg(s)	Toe(s)	Chest	Ribs	Tailbone

Have you seen any other health care professional(s) for this condition or reason? ☐Yes ☐No
If yes whom?_____

Have you ever been involved in any motor vehicle accidents? ☐Yes ☐No **Date:** _____
Have you been involved in any other accidents? ☐Yes ☐No _____

Briefly list any surgeries you have undergone, for what and when

_____
_____

Are you presently taking any prescribed medication(s)? ☐Yes ☐No
If yes, please list the medication(s) and the condition(s) for which is it being used if known.

_____
_____

Have you previously received massage therapy treatments? ☐Yes ☐No
If yes, were you treated? ☐At this clinic ☐ From an RMT ☐ Other

Please circle on the following scales the extent to which you are currently satisfied with the following:
(5 represent total satisfaction) 1 represents little or no satisfaction)

Physical health & fitness	5	4	3	2	1
Mental & emotional happiness	5	4	3	2	1
Energy level	5	4	3	2	1
Diet	5	4	3	2	1
Ability to relax	5	4	3	2	1

I acknowledge that the Massage 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 ailment 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 and understand that the Massage Therapist must be fully aware or my existing medical conditions. I have completed my medical history form as provided by my Massage Therapist and disclosed 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.

_____ _____ Esperanza Costes
Signature Date Therapist

OFFICE POLICY

MISSED APPOINTMENT & CANCELLATION FEES

A fee will be charged to your account for ALL missed appointments.

Fees are as follows ...

MISSED APPOINTMENTS :

30 min. Massage Therapy Appointment	$45
45 min. Massage Therapy Appointment	$45
60 min. Massage Therapy Appointment	$45
90min. Massage Therapy Appointment	$90
120 min. Massage Therapy Appointment	$90

CANCELLATION FEES :

POLICY : We require 12 HOURS NOTICE for cancellation of your appointment. If less than 12 hours is given, your account will be charged (see fees above) UNLESS the appointment is filled but this is NOT guaranteed.

Signature : _____

Date: _____

Cupping Therapy

Client Release Form

- I understand that all treatments at this facility are therapeutic in nature. I agree to communicate to the Therapist any physical discomfort or draping issues during the session.

- Information has been provided to me about Cupping Therapy. If I choose to experience these Therapies during treatments, I understand the potential effects and after-care recommendations.

- It has been explained to me that there are contraindications for Cupping Therapy. I have fully disclosed all health factors to my therapist, including those not mentioned on my Health History Intake Form, to avoid any complications.

- It has been explained to me that there is the possibility of discolorations that can occur from the release and clearing of stagnation and toxins from my body.

- I also understand that this reaction is not bruising, but do to cellular debris, pathogenic factors and being drawn to the surface to be clear away by my circulatory systems.

- I further understand that the discoloration will dissipate from a few hours to as long as 2 weeks in some cases and in relation to my after-care activities.

- I understand that cupping Therapy modalities should not be combined with aggressive exfoliation, 4 hrs after shaving, after sunburn or when I'm hungry or thirsty.

- I understand that I should avoid exposure to extreme cold, wet, and/or windy weather conditions, hot showers, baths saunas, hot tubs and aggressive exercise for 24 hours. It has been explain to me that exposure to such extremes can produce undesirable effects and I should avoid such situations.

- I understand that I should avoid caffeine, alcohol, sugary foods and drinks, dairy and processed Meats and I should consume an abundance of clean water.

I _____ agree to allow the Cupping Practitioner to perform Cupping. I also agree that I have read, understand and will follow of the information stated above And will not hold the practitioner responsible.

Date_____ Signature or client_____

Date_____ Signature of Practitioner

Print Name_____