

PowerHealth

Date: _____
Last Name: _____ First Name: _____ Middle Name: _____
Sex: M F
Date of Birth: (D/M/Y) _____
Alberta Health Care #: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Home Phone #: _____
Cell Phone #: _____
Bus Phone #: _____
Fax #: _____
Email: _____
Employer: _____ Occupation: _____
Do you have extended medical coverage? Y N Company: _____
Main Injury/ Chief Complaint: _____
Onset: _____
Activities that aggravate: _____
Activities that alleviate: _____
Previous injuries: _____
Previous surgeries: _____

Please indicate the frequency, and quantity of the following:

Alcohol : _____ Tobacco : _____
Coffee : _____ Vitamins: _____
Exercise : _____ Supplements: _____

Are you presently taking prescribed medication(s) ? If yes, please list: _____

Please check if any of the following conditions are applicable to you:

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Painful menstruation |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Grinding of teeth | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pregnant/
Attempting |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pins/ Plates |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Spinal Injury |
| <input type="checkbox"/> Contact lenses | <input type="checkbox"/> Hernia | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Others: _____ |
| <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Indigestion | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Insomnia | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Low back pain | |

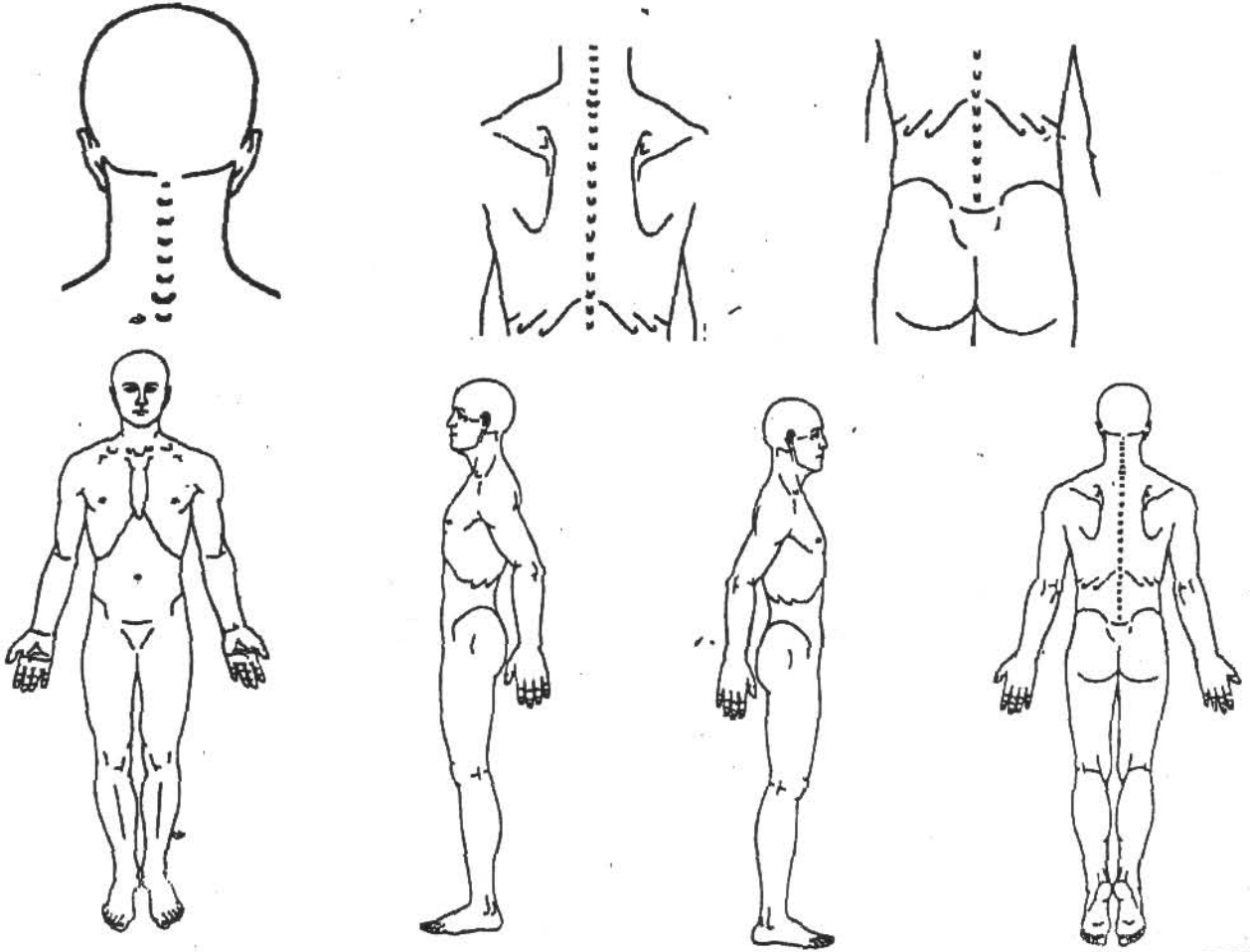
Who is your Family Physician?

Are you presently under the care of a Chiropractor? Y N If yes, who?

Are you presently under the care of a Physiotherapist? Y N If yes, who?

Are you presently under the care of a Naturopath? If yes who?

Please indicate the areas of your pain or discomfort:



I, _____ understand massage therapy given at the
PowerHealth is for the purpose of soft tissue injury relief, and or relaxation.

I understand that the massage therapist will not offer diagnosis of illness, disease, or other physical or mental disorders. As such, the massage therapist prescribes neither medical treatment nor pharmaceuticals, nor performs any chiropractic manipulations.

It has been made very clear to me that this massage therapy is not a substitute for medical or dental examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Because a massage therapist must be aware of the client's pre-existing conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

I understand that payment is required at the time the service is rendered. I also understand that if I can not attend my scheduled appointment, I must notify the clinic 24 hours or more in advance. If I do not, I will be charged 50 % of the cost of the appointment.

Signature _____
Witness _____

Date _____
Date _____