Health History (Age 13 and older)

A complete health history helps ensure it is safe to provide you with a manual treatment; please inform me if your status changes so we can update your form. **All information given is confidential.**

Name _____Email_____

Home Phone_____ Cell Phone_____ Work Phone_____

Street_____ Unit_____ City_____ Prov.____ Postal Code_____

Date of Birth (MM-DD-YY)_____ Age____ Occupation_____

If yes, were you referred by your doctor? Yes No

Doctor's Name_____ Phone_____ Last Check-Up Date_____

Doctor's Street_____ Unit _____City_____ Prov._____ Postal Code_____

Do you see other healthcare practitioners? Chiro Physio Naturopath RMT Osteopath Other

Current Medications_____

Previous Major Accidents (include dates)_____

Previous Surgeries (include dates)_____

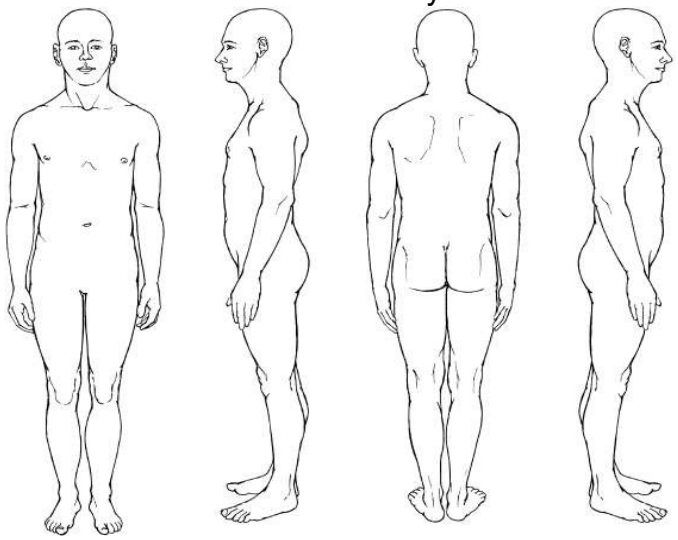
Other Serious Medical Conditions_____

Allergies/Hypersensitivities_____

Family History of_____

What are your areas of complaint?_____

Please indicate areas you would like us to focus on and your areas of complaint.



Health History and Entrance Form (please check all that apply to you)

General Symptoms

- ▯ Fainting / Dizziness
- ▯ Difficulty Sleeping /
- ▯ Fatigue
- ▯ Stress
- ▯ Depression
- ▯ Anxiety
- ▯ Headaches / Migraines
- ▯ Nervousness
- ▯ Numbness / Tingling; Where:_____
- ▯ Paralysis

Skin

- ▯ Rashes
- ▯ Excessive Dryness
- ▯ Acne
- ▯ Psoriasis
- ▯ Eczema
- ▯ Skin Cancer
- ▯ Bruise Easily

Immune/Infections

- ▯ Hepatitis
- ▯ Cancer; Where_____
- ▯ Tuberculosis
- ▯ HIV / AIDS
- ▯ Herpes
- ▯ Athlete's Foot
- ▯ Warts
- ▯ Lupus
- ▯ Rheumatoid arthritis
- ▯ Skin condition_____

Respiratory

- ▯ Chronic Cough
- ▯ Bronchitis
- ▯ Asthma
- ▯ Shortness of Breath
- ▯ Emphysema
- ▯ Respiratory disease_____
- ▯ COPD

Joint / Muscle Discomfort

- ▯ Jaw
- ▯ Neck
- ▯ Shoulders
- ▯ Arms
- ▯ Hands
- ▯ Upper Back
- ▯ Mid Back
- ▯ Low Back
- ▯ Hips
- ▯ Legs
- ▯ Knees
- ▯ Feet
- ▯ Bursitis, where_____
- ▯ Arthritis, where_____
- ▯ Gout
- ▯ Osteoporosis
- ▯ Osteoarthritis, where_____
- ▯ Artificial Implants / Pins / Plates; Where_____
- ▯ Fibromyalgia
- ▯ Neuromuscular Conditions_____
- ▯ Multiple Sclerosis
- ▯ Scoliosis
- ▯ Fractures, where_____
- ▯ Whiplash
- ▯ Degenerative disc disease

Do You Have / Had?

- ▯ Epilepsy
- ▯ Kidney stones
- ▯ Bladder infections
- ▯ Kidney disease
- ▯ Urinary incontinence
- ▯ Hypo / Hyper thyroid
- ▯ Epilepsy

Male / Female

- ▯ Prostate
- ▯ Pregnant; Due Date_____
- ▯ Menstrual Cramping
- ▯ Menstrual Irregularity
- ▯ Birth Control
- ▯ Vaginal Pain / Infections
- ▯ Breast Pain / Lumps
- ▯ Menopausal

Cardiovascular

- ▯ High Blood Pressure
- ▯ Low Blood Pressure
- ▯ Heart Attack / Disease
- ▯ Congestive Heart Failure
- ▯ Angina
- ▯ Lymphedema
- ▯ Stroke / Aneurysm
- ▯ Heart Murmur
- ▯ Pacemaker
- ▯ High Cholesterol
- ▯ Swelling of Ankles
- ▯ Raynaud disease
- ▯ Poor Circulation
- ▯ Feet
- ▯ Varicose Veins / Phlebitis
- ▯ Family History of_____

Gastrointestinal

- ▯ Poor / Excessive Appetite
- ▯ Diabetes
- ▯ Excessive Thirst
- ▯ Gas / Bloating
- ▯ Colitis
- ▯ Celiac disease
- ▯ Crohn's disease
- ▯ Hypo / Hyper Glycaemic
- ▯ Constipation / Diarrhea
- ▯ Nausea / Vomiting
- ▯ Esophageal / Stomach / Intestinal Ulcers
- ▯ Abdominal Cramps
- ▯ Gall Bladder Problems
- ▯ Liver Problems
- ▯ Diverticulitis
- ▯ Esophageal disorder

EENT

- ▯ Vision Problems
- ▯ Dental Problems
- ▯ Sore Throat
- ▯ Meniere disease / Vertigo
- ▯ Ear Aches
- ▯ Hearing Difficulty / Aid
- ▯ Tinnitus
- ▯ Stuffed Nose / Sinus
- ▯ Allergies / Hypersensitivity to

Type of Reaction_____

- ▯ Swollen lymph nodes / glands, where_____

Lifestyle (circle all that apply)

Regular Exercise	Yes	No	Mostly
Drink Plenty of Water	Yes	No	Mostly
8 Hours of Sleep nightly	Yes	No	Mostly
Good Eating Habits	Yes	No	Mostly

Describe your general health?_____

Please read and sign:

- I attest that the information I have provided is true and complete to the best of my knowledge.
- I understand the information I have provided on this form is confidential and will not be released without my written consent.
- I understand that the therapist can end treatment at anytime due to inappropriate behaviour.
- I consent to a health assessment/reassessments and therapeutic massage treatment of Sonya Romanowski – B.Sc. Kin, RMT, DOMP, DSc O
- I authorize Sonya Romanowski – DOMP, D Sc O, RMT, R.Kin (Inactive) to contact my doctor or other health care professional listed above if required for treatment purposes.
- I understand that all sessions include a pre-health assessment and change time.
- I understand 24 hours notice is required to reschedule all future appointments, or full charges will apply.
- **If I have suspected or positive COVID-19 symptoms, I can cancel my appointment within 24 hours notice.**

Signature _____ Today's Date_____

INFORMED CONSENT
PLEASE READ AND SIGN

I verify that all information is correct and current to the best of my knowledge. I understand that any information provided is for safety purposes and will be kept strictly confidential.

I hereby give my consent to receive manual therapy and/or other bodywork or treatment (the "Services") from Sonya Romanowski – B.Sc. Kin, RMT, DOMP, DSc O and I acknowledge and agree that I am doing so at my own risk. My health and safety with respect to such Services are my sole responsibility. I acknowledge that my receipt of the Services from Sonya Romanowski – B.Sc. Kin, RMT, DOMP, DSc O may result in bodily injury to me. My decision to receive Services from Sonya Romanowski – B.Sc. Kin, RMT, DOMP, DSc O is voluntary, and I know of, understand and assume any and all the risks associated therewith.

In exchange for receiving Services from Sonya Romanowski – B.Sc. Kin, RMT, DOMP, DSc O I, for myself and on behalf of my heirs, executors, administrators and personal representatives, hereby waive, release, discharge and hold harmless Sonya Romanowski – B.Sc. Kin, RMT, DOMP, DSc O from any and all liability for any and all injuries, including death, damages or claims relating to or resulting from my receipt of the Services, now or in the future, foreseen or unforeseen. Further, I will indemnify and hold Sonya Romanowski – B.Sc. Kin, RMT, DOMP, DSc O, its members, officers, agents and employees, harmless from and against any and all claims, rights, damages, liabilities, losses, costs and expenses (including reasonable attorneys' fees) arising from or in connection with any injuries to other persons or damage to property caused by or attributed to me.

I acknowledge that Sonya Romanowski – B.Sc. Kin, RMT, DOMP, DSc O is not a medical physician and does not diagnose illness, disease or any other physical or mental disorder. I clearly understand that the "Services" offered 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 and understand that Sonya Romanowski - B.Sc. Kin, RMT, DOMP, DSc O 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 Sonya Romanowski – B.Sc. Kin, RMT, DOMP, DSc O updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I acknowledge that I have read, and understand, and I have had the opportunity to question the contents and my therapy; the release and indemnification provisions set forth in the preceding paragraph, and agree to such terms.

Patient Name _____

Signature of Patient/Guardian_____

Therapist Signature _____

Date Signed_____