2B FREE THERAPIES

CONFIDENTIAL CASE HISTORY FORM

Name: _____ Phone: (H): _____ (W/C): _____

Email: _____

Address: _____ City: _____ Postal Code: _____

Date of Birth: _____ Occupation: _____

Emergency Contact: Name/Relationship: _____
Phone:
Physician Name & Address: _____

_____

What brings you to treatment today? _____

Have you been previously treated for this condition? Yes ☐ No ☐

If yes, by whom? _____

Current Medications and Vitamins: _____

_____

Any medications taken in the last 2 hours? Yes ☐ No ☐

If yes, what kind? _____

Are you experiencing pain now? Yes ☐ No ☐

Energy Level: High ☐ Medium ☐ Low ☐
Stress Level: High ☐ Medium ☐ Low ☐

Previous Injuries/Surgeries/Serious Illness/Hospitalizations

1. Type: _____

   Date: _____

   Explain: _____

2. Type: _____

   Date: _____

   Explain: _____

PLEASE CHECK OFF CONDITIONS YOU CURRENTLY EXPERIENCING OR HAVE EXPERIENCED

HEAD/NECK
- ☐ headaches (type)
- ☐ vision problems
- ☐ hearing problems
- ☐ contact lenses
- ☐ earaches

RESPIRATORY
- ☐ chronic cough
- ☐ asthma
- ☐ shortness of breath
- ☐ bronchitis/emphysema
- ☐ smoker
- ☐ other

CARDIOVASCULAR
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ poor circulation
- ☐ heart disease
- ☐ myocardial infarction
- ☐ pacemaker
- ☐ phlebitis
- ☐ varicose veins
- ☐ hemorrhagic
- ☐ Dr. diagnosed

SKIN
- ☐ skin conditions (type)
- ☐ bruise easily

INFECTION
- ☐ herpes
- ☐ hepatitis
- ☐ plantar warts
- ☐ tuberculosis
- ☐ H.I.V

OTHER CONDITIONS
- ☐ difficult digestion
- ☐ bowel/G.I.
- ☐ constipation/diarrhea
- ☐ liver
- ☐ gallbladder
- ☐ kidney
- ☐ diabetes
- ☐ sinus
- ☐ allergies
- ☐ insomnia
- ☐ cancer
- ☐ rheumatoid arthritis
- ☐ osteoarthritis
- ☐ thyroid

FEMALE
- ☐ menstrual problems (type)
- ☐ c-section/other surgeries
- ☐ pregnant
- ☐ menopause
- ☐ infertility
- ☐ planning children

MUSCLES
- ☐ neck
- ☐ low back
- ☐ middle back
- ☐ upper back/shoulders
- ☐ legs left right
- ☐ knees left right
- ☐ feet left right
- ☐ arms/hands left right
- ☐ other

OTHER HEALTHCARE
- ☐ Chiropractor
- ☐ Massage therapy
- ☐ Athletic Therapy
- ☐ Physiotherapy
- ☐ Osteopathy
- ☐ Regular exercise
- ☐ Other

Any wires, pins, artificial limbs, special equipment: Yes ☐ No ☐

ADDITIONAL INFORMATION: _____

_____

INFORMED CONSENT

IT IS MY CHOICE TO RECEIVE THERAPY (Athletic Therapy &/or Massage Therapy &/or Fascial Stretch Therapy &/or Acupuncture) AND I UNDERSTAND THAT THE TREATMENT THAT IS BEING GIVEN IS FOR THE WELLBEING OF MY BODY AND MIND. I AGREE TO COMMUNICATE WITH MY THERAPIST THAT MY WELLBEING IS BEING COMPROMISED. I UNDERSTAND THAT THE THERAPIST WILL OUTLINE THE TREATMENT AND WILL COMENCE TREATMENT ONCE CONSENT HAS BEEN OBTAINED. I UNDERSTAND THAT I MAY STOP THE TREATMENT AT ANYTIME I MAY CHOOSE. I UNDERSTAND THAT THE THERAPIST PERFORMING THE TREATMENT IS NOT A MEDICAL DOCTOR NOR IS HE/SHE DIAGNOSING, PRESCRIBING, REPLACING THE SERVICES OF MY FAMILY PHYSCIAN. I UNDERSTAND THAT AT LEAST 24HRS NOTICE PRIOR TO CANCELLING AN APPOINTMENT IS REQUIRED OR I WILL BE CHARGED FOR THE MISSED APPOINTMENT.

_____ _____

Signature: Date:

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TREATMENT LOG

Client Name:

Date/Fee Pd	TREATMENT