Remedial Wellness Centre

Confidential Case History Form

Shockwave Therapy/ Massage Therapy

Date: ________________

Name: ________________________________ MALE ☐ FEMALE ☐

Address: ____ City________________ Prov: ________

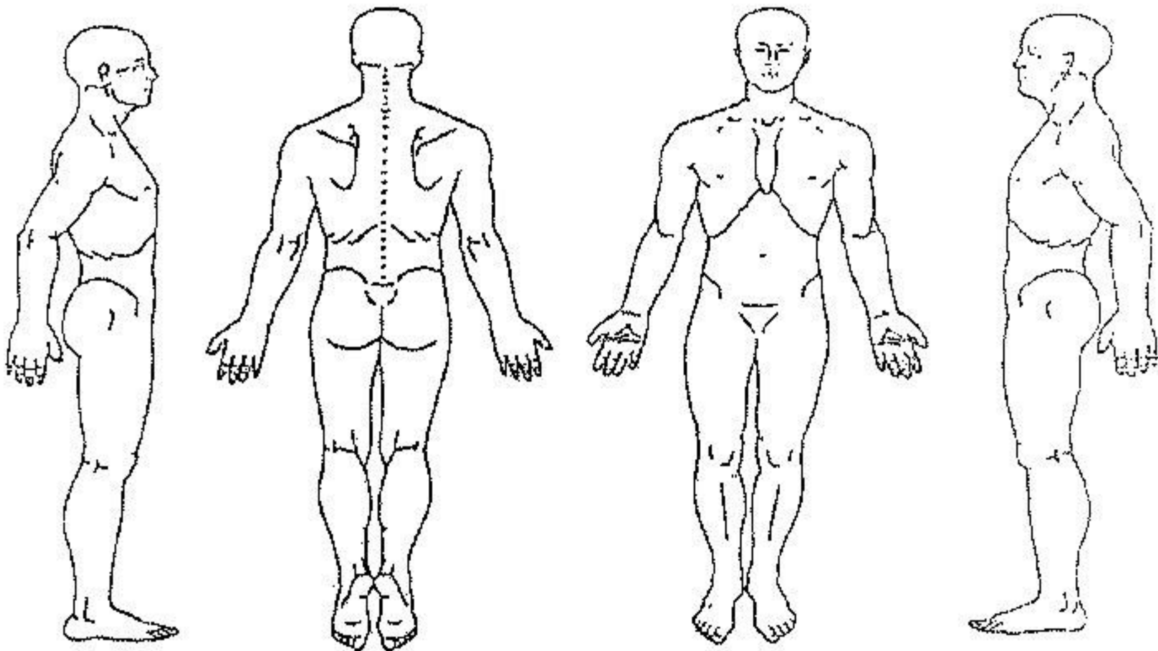
Postal Code: ______________ Home Phone: ___________________ Email: _______________________

Date of Birth: ___________________________ (dd/mm/yyyy) Occupation: ____________________________

Medical Doctor:___________________________________ MD Phone:_________________________________

Whom may we thank for referring you? ____________________________________

Please indicate (circle) for the Therapist where your pain is located:



Please indicate the conditions you are experiencing or have experienced:

Cardiovascular	**Respiratory**	**Digestive**
□ 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	□ Asthma □ Bronchitis □ Emphysema □ Chronic Cough □ Shortness of breath □ *Is there a family history of any of the above?* □ YES □ NO	□ Constipation □ Crohn's Disease □ Colitis □ Irritable Bowel Syndrome □ Ulcers
Head & Neck □ History of headaches □ Migraines □ Vision problems □ Vision loss □ Ear problems □ Hearing loss	**Muscle & Joint** □ Neck □ Low-Back □ Mid-Back □ Upper-Back □ Shoulders □ Elbow □ Wrist/Hand □ Hip □ Knee □ Ankle/Foot □ Spine	**Other** □ Loss of sensation *If so, where?* ____________ □ Diabetes *Onset:*_________________ *Type:* _________________ □ Allergies *To what?* ______________ □ Epilepsy □ Cancer *Type:* _________________ *Location:* ______________ □ Arthritis *Family history? Y / N* □ Hemophilia □ Fibromyalgia □ Chronic fatigue □ Scoliosis □ Polio/Post polio □ Osteoporosis
Women □ Are you pregnant? Y / N *If yes, due date?* _____________ □ Previous pregnancy complications: _____________________ _____________________ _____________________ □ Menopausal problems: _____________________ □ Menstrual problems: _____________________ □ Gynecological conditions: _____________________	**Infectious Conditions** □ Skin conditions *Describe:* __________________ □ Respiratory conditions: *Describe:* __________________ □ Hepatitis **Skin Conditions** □ Eczema □ Psoriasis □ Rash □ Warts □ Open Sores	**Men** □ Enlarged Prostate □ Libido Issues □ Other _____________________ _____________________ _____________________

Do you have any medical conditions not listed above? *If yes, please explain:* ____________________
____
____

Do you have any internal wires, artificial joints, pacemakers or special equipment that we should be aware of? ____
____
____

For what condition or reason are you seeking treatment today? ______________________________
____
____

Have you seen any other health care professional(s) for this condition? *If so, whom?* _____________
____

Have you ever been involved in a Motor Vehicle Accident? Y / N

Have you ever been involved in any other accidents? Y / N

Have you ever been knocked unconscious? Y / N

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

Are you presently taking any prescribed medications? Y / N *If yes, please list the medication(s) and the condition(s) for which it is being used if known.* _______________________________________
____
____

Have you previously received massage therapy treatments? Y / N *If yes, please indicate where and by whom.* ____

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

Physical Health & Fitness	1	2	3	4	5
Mental and Emotional Happiness	1	2	3	4	5
Energy Level	1	2	3	4	5
Diet	1	2	3	4	5
Ability to Relax	1	2	3	4	5

Informed Consent to Shockwave Therapy/ Massage Therapy

I acknowledge that the Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that shockwave therapy/ massage therapy is not a substitute for 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 me as the results of the treatment.

I acknowledge and understand that the Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Therapist and disclosed all of those medical conditions affecting me. It is my responsibility to keep the Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

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Signature of Client Date

____

Signature of Witness Date

Ear Protection

All clients presenting for shockwave or acoustic wave treatments must wear clinic-supplied, disposable ear plugs during treatment.

***There is no potential for hearing loss or damage as a result of shockwave therapy**; however, there can be some impairment for a couple of days after a treatment that occurs around the neck and skull. This is not a result of the noise from the device during treatment, this is due to the proximity of the sound waves to the structures of the ear. Within an extremely short window post-treatment, hearing will return to normal levels.

If you do not want to wear plugs, you must initial that you have waived your right to ear protection. __________

Shockwave Therapy/Massage Therapy/ Cancellation Policy

Please be advised that there is a 12 hour missed/cancelled appointment policy in effect for Shockwave Therapy/ Massage Therapy at Remedial Wellness Centre. Late cancellations (within 12 hours) and missed appointments will be charged 50% of the appointment fee. The same applies if the therapist misses an appointment with a client; (the client's next appointment will be 50% of the full fee).

In order to be consistent with all clients, cancellation fees will only be waived in the event of a medical emergency requiring urgent professional treatment, a major event in the family, or natural disaster.

We are committed to providing you with the highest quality service possible and we ask that you understand that it is nearly impossible to fill appointments spots on the day they are cancelled. Thank you for your understanding and we look forward to helping you on your way to better health.

I hereby confirm that I have read, understand and agree to the above terms.

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Signature of Client Date

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Signature of Witness Date