

Confidential Case History Form for Shockwave Therapy

Date: _____

Name: _____ MALE FEMALE

Address: _____ City: _____ Prov: _____

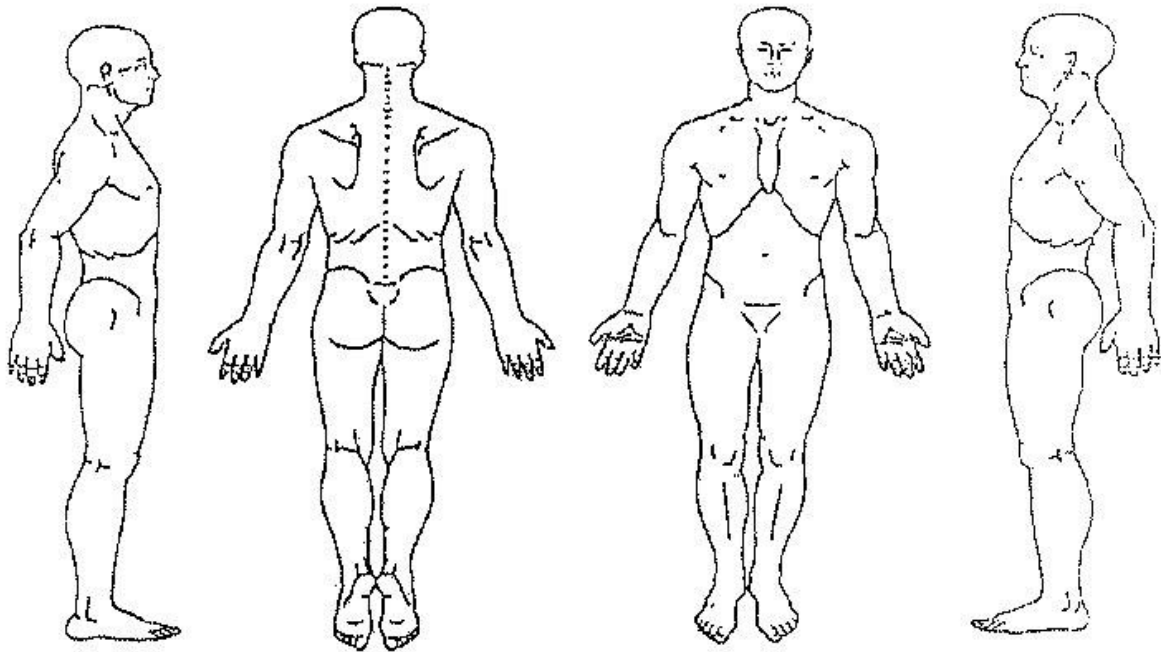
Postal Code: _____ Home Phone: _____ Email: _____

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:

<p><u>Cardiovascular</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Chronic congestive heart failure <input type="checkbox"/> Heart Attack <input type="checkbox"/> Phlebitis/Varicose veins <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> Pacemaker or similar device <input type="checkbox"/> Heart Disease <input type="checkbox"/> Dizziness/Vertigo <input type="checkbox"/> Seizures <input type="checkbox"/> <i>Is there a family history of any of the above?</i> <input type="checkbox"/> YES <input type="checkbox"/> NO 	<p><u>Respiratory</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> <i>Is there a family history of any of the above?</i> <input type="checkbox"/> YES <input type="checkbox"/> NO 	<p><u>Digestive</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Constipation <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Colitis <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Ulcers
<p><u>Head & Neck</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> History of headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Vision problems <input type="checkbox"/> Vision loss <input type="checkbox"/> Ear problems <input type="checkbox"/> Hearing loss 	<p><u>Muscle & Joint</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Neck <input type="checkbox"/> Low-Back <input type="checkbox"/> Mid-Back <input type="checkbox"/> Upper-Back <input type="checkbox"/> Shoulders <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist/Hand <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle/Foot <input type="checkbox"/> Spine 	<p><u>Other</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Loss of sensation <i>If so, where? _____</i> <input type="checkbox"/> Diabetes <i>Onset: _____</i> <i>Type: _____</i> <input type="checkbox"/> Allergies <i>To what? _____</i> <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cancer <i>Type: _____</i> <i>Location: _____</i> <input type="checkbox"/> Arthritis <i>Family history? Y / N</i> <input type="checkbox"/> Hemophilia <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> Scoliosis <input type="checkbox"/> Polio/Post polio <input type="checkbox"/> Osteoporosis
<p><u>Women</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Are you pregnant? Y / N <i>If yes, due date?</i> _____ <input type="checkbox"/> Previous pregnancy complications: _____ _____ <input type="checkbox"/> Menopausal problems: _____ <input type="checkbox"/> Menstrual problems: _____ <input type="checkbox"/> Gynecological conditions: _____ 	<p><u>Infectious Conditions</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Skin conditions <i>Describe:</i> _____ <input type="checkbox"/> Respiratory conditions: <i>Describe:</i> _____ <input type="checkbox"/> Hepatitis <p><u>Skin Conditions</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Rash <input type="checkbox"/> Warts <input type="checkbox"/> Open Sores 	<p><u>Men</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Enlarged Prostate <input type="checkbox"/> Libido Issues <input type="checkbox"/> 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

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 shockwave 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 Massage Therapist must be fully aware of 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.

Signature of Client Date

Signature of Witness Date

Shockwave Therapy Cancellation Policy

Please be advised that there is a 12 hour missed/cancelled appointment policy in effect for Shockwave Therapy at the Derrick Spa. 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.

Signature of Client Date

Signature of Witness Date