powerhealth
John Power, RMT, ART® Provider

DATE: _____

LAST NAME: _____ *FIRST NAME:* _____

DATE OF BIRTH: _____ SEX: MALE _____ FEMALE _____

ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE:_____

HOME PHONE: _____CELL PHONE: _____

EMPLOYER: _____ WORK PHONE: _____

REFERRED BY: _____

If you would like to receive appointment reminders please fill out:
Email or cell number:_____
Cell Provider:_____ **Morning of appt / Day before (cirle one)**

PRIMARY COMPLAINT: _____

ONSET: _____

PREVIOUS INJURIES: _____

PREVIOUS SURGERIES: _____

HOW MUCH PAIN ARE YOU IN: 1 2 3 4 5 6 7 8 9 10 (1 = VERY MILD, 10 = EXTREME)

WHAT IS YOUR URGENCY TO IMPROVE YOUR CONDITION: 1 2 3 4 5 6 7 8 9 10 (1 = NOT URGENT,10 = EXTREMELY URGENT)

PLEASE INDICATE THE FREQUENCY AND QUANTITY OF THE FOLLOWING:
ALCOHOL: _____ TOBACCO: _____
COFFEE: _____ VITAMINS: _____
EXERCISE: _____ SUPPLEMENTS: _____

ARE YOU PRESENTLY TAKING PERSCRIBED MEDICATION(S)? *IF YES, LIST*
_____

ARE YOU PRESENTLY UNDER THE CARE OF A CHIROPRACTOR? *IF YES, WHO?*
_____

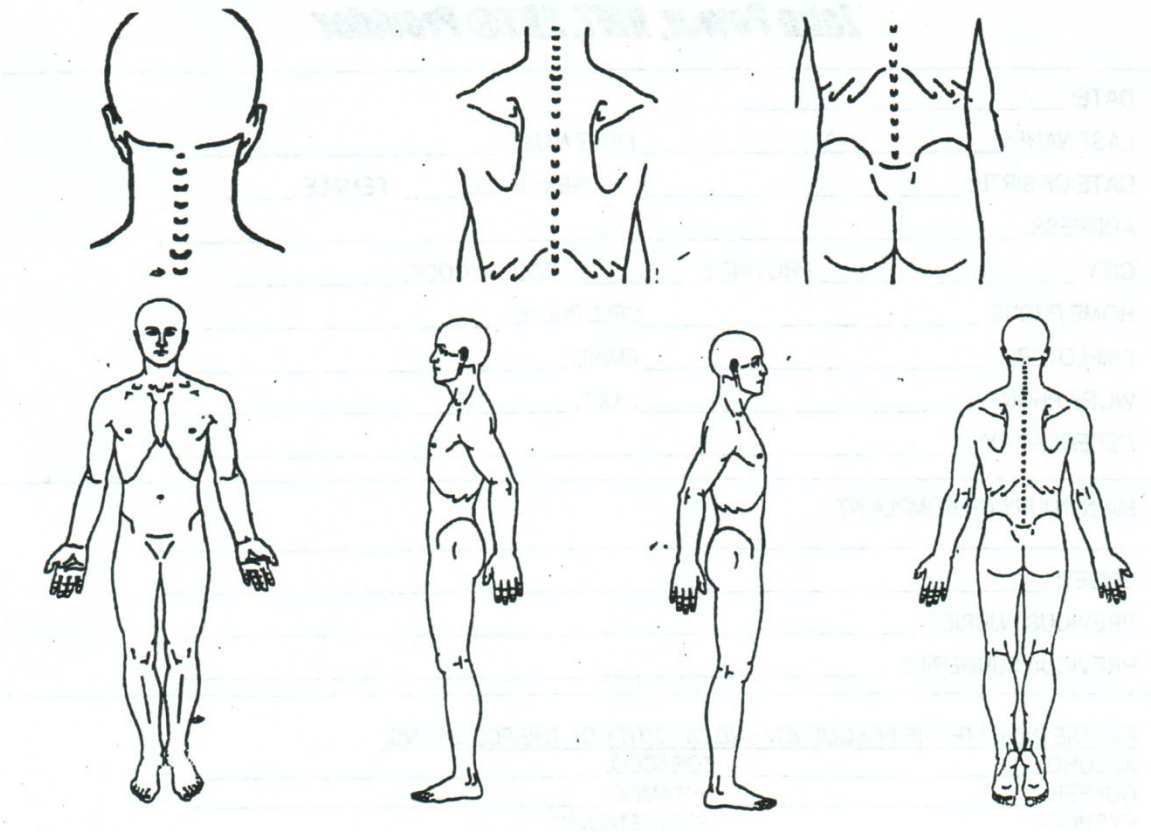
ARE YOU PRESENTLY UNDER THE CARE OF A PHYSIOTHERAPIST? *IF YES, WHO?*
_____

PLEASE CHECK IF ANY OF THE FOLLOWING CONDITIONS ARE APPLICABLE TO YOU:

ALLERGIES
HIGH BLOOD PRESSURE
BRONCHITIS
CANCER
CONSTIPATION
CONTACT LENSES
DIABETES
DIGESTIVE DISORDERS
DIZZINESS
EPILEPSY
FIBROMAYALGIA
FATIGUE
GRINDING OF TEETH
HEADACHES
HEART DISEASE
HIV/AIDS
HERNIA
HYPOGLYCEMIA
INDIGESTION
INSOMNIA
LOWBACK PAIN
NERVOUSNESS
PAINFUL MENSTRUATION
PARALYSIS
PREGNANT/ATTEMPTING
PINS/PLATES
SPINAL INJURY
VOMITING
OTHER: _____

Cont'd →

PLEASE INDICATE YOUR SPECIFIC AREAS OF PAIN OR DISCOMFORT:



I, _____, understand massage therapy (active release technique) given at **Power Health** is for the purpose of soft tissue injury relief.

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 adjustments.

It has been made very clear to me that this massage therapy (active release technique) is not a substitute for medical or dental examinations and/or diagnosis and that it is recommended that I see a physician/chiropractor 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.

For patients being co-managed within Power Health, please initial here to give your consent for consultation between practitioners regarding the management of your case. Initial _____

I understand that payment is required at the time the service is rendered. I also understand that if I cannot 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. Initial _____

Signature_____

Date_____

Witness_____