

Best of Health Massage Therapy

Client Information & Bowen Therapy Waiver

Client Name: _____ Birthdate: _____

Center/Residence: _____ Room #: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone Number: _____

Family Contact: _____ Relationship: _____

Phone Number: _____ Email: _____

Billing Information: *Check if billing address is same as above*

Attention: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Invoice delivery preference: Canada Post Email

Bowen Therapy Waiver:

By signing this form, I indicate a willingness to accept any result of the treatment conducted or recommended by this therapist, without holding the clinic or therapist liable for any circumstance, condition or aggravation of thereof treatment may influence or cause. This treatment does not in any way replace medical treatment where necessary.

Cancellation Policy:

Please note that 24 hours' notice is required to re-schedule or cancel appointments. If less than 24 hours' notice is given, or an appointment is missed, a **\$50 fee** will be applied. To change an appointment, please call 587.775.1514 or use the online booking calendar at www.bohm.ca

Client Name: _____

Client/POA Signature: _____

Date: _____

Best of Health Massage Therapy - Confidential Client Medical History

This history is strictly confidential and will not be released to anyone without your prior written consent. The information gathered will help determine the appropriate type of procedures to be included in your treatment plan.

NAME: _____ DATE: _____

Please indicate which conditions you currently suffer from or have suffered from in the past:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Chronic Fatigue Syndrome |
| <input type="checkbox"/> PTSD | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Depression | <input type="checkbox"/> Adrenal Fatigue | <input type="checkbox"/> Scoliosis/Lordosis/Kyphosis |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stressed/Overwhelmed |
| <input type="checkbox"/> Heart Disease <i>List type:</i> | | <input type="checkbox"/> Cancer <i>List Location(s):</i> | |
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- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Hamstring Pain | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Slipped/Herniated/Bulging Disc |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Degenerative Disc Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ankle Pain | <input type="checkbox"/> Drop Foot | <input type="checkbox"/> Abnormal Gait (walk) |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Heel Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Incontinence/Bladder Issues |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Plantar Fasciitis | <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Gynecological Problems |

- | | | | |
|---------------------------------------|--|--|---|
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Migraines | <input type="checkbox"/> Difficulty Swallowing Food |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Frozen Shoulder or Injury |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Dry/Runny/Itchy
Eyes | <input type="checkbox"/> Grind/Clench Teeth |
| <input type="checkbox"/> Mucus Cough | <input type="checkbox"/> Earaches | <input type="checkbox"/> Impaired Vision | <input type="checkbox"/> Tension Headaches |
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> TMJ/ Jaw Pain | <input type="checkbox"/> Kinked Neck | <input type="checkbox"/> Rib Pain or Injury |
| <input type="checkbox"/> Sinus Issues | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Sternal Pain | <input type="checkbox"/> Concussion <i>Date(s):</i> _____ |
| <input type="checkbox"/> Tennis Elbow | <input type="checkbox"/> Whiplash | | <input type="checkbox"/> Tailbone Pain or Injury |

- | | | | |
|---|--------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Skin Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Gas | <input type="checkbox"/> Respiratory Issues |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Allergies | <input type="checkbox"/> Bloating | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Colitis | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Edema | <input type="checkbox"/> Heartburn | <input type="checkbox"/> IBS | |

- Osteoporosis
- Neuropathy
- Lupus
- Parkinson's Disease
- Muscular Dystrophy
- Rheumatoid or Osteo Arthritis

For any of the following that are applicable, please list location(s) and/or type:

- Implants _____
- Fusions _____
- Sprains _____
- Broken Bones _____
- Contagious Conditions _____
- Tendinitis _____
- Blood Clots _____
- Limited Range of Motion _____

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NAME: _____ DATE: _____

Please make an X or circle over areas where you experience pain or discomfort.

The diagram consists of four line drawings of a human body from the waist up and down, arranged horizontally. From left to right: 1. Front view of the torso and legs. 2. Back view of the torso and legs. 3. Profile view of the left side of the body. 4. Profile view of the right side of the body. Below the third and fourth drawings are the labels 'LEFT' and 'RIGHT' respectively. The entire diagram is enclosed in a rectangular border.

Please list any other relevant conditions or concerns:
