Best of Health Inc.

Client Information & Waiver Form

Client Name:_____ Birthdate:_____

Address:_____

City:_____ Province:_____ Postal Code: _____

Home Phone :_____ Cell Phone: _____

Email:_____

Occupation:_____

Referred by: _____

Goal(s) for this treatment: _____

For Clients Under 18:

Guardian Name:_____ Relationship: _____

Phone Number: _____

Email: _____

Bowen & Massage 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 48 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/Guardian Signature: _____

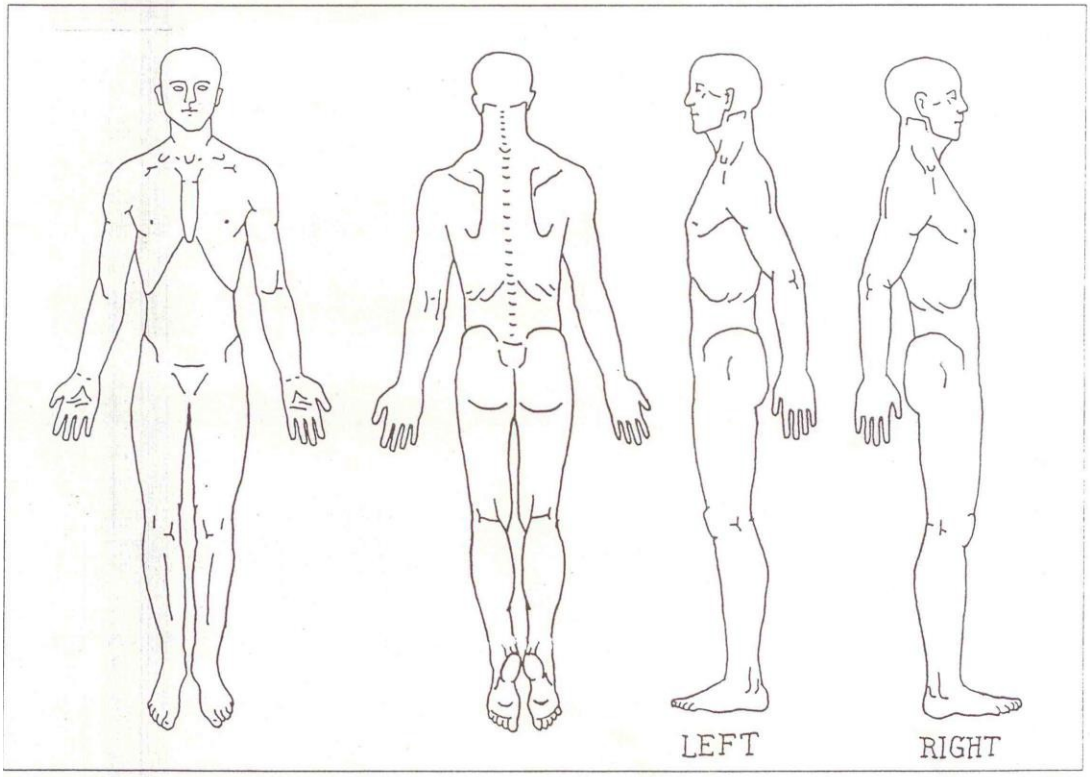
Date: _____

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



Please list any injuries, surgeries, previous traumas, or other concerns:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please indicate if you currently suffer from, or have suffered from in the past:

Current/Past		Current/Past		Current/Past	
❑	❑ Anxiety	❑	❑ Plantar Fasciitis	❑	❑ Sternal Pain
❑	❑ PTSD	❑	❑ Prostrate Problems	❑	❑ Postural Issues
❑	❑ ADHD	❑	❑ Hemorrhoids	❑	❑ Difficulty Swallowing Food
❑	❑ Seizures	❑	❑ Drop Foot	❑	❑ Frozen Shoulder or Injury
❑	❑ Autism	❑	❑ Constipation	❑	❑ Grind/Clench Teeth
❑	❑ Insomnia	❑	❑ Chronic Diarrhea	❑	❑ Tension Headaches
❑	❑ Epilepsy	❑	❑ Slipped/Herniated/Bulging Disc	❑	❑ Rib Pain or Injury
❑	❑ Depression	❑	❑ Degenerative Disc Disease	❑	❑ Tailbone Pain or Injury
❑	❑ Panic Attacks	❑	❑ Abnormal Gait (walk)	❑	❑ Diverticulitis
❑	❑ Atrial Fibrillation	❑	❑ Incontinence/Bladder Issues	❑	❑ Edema
❑	❑ Cerebral Palsy	❑	❑ Gynecological Problems	❑	❑ Asthma
❑	❑ Fibromyalgia	❑	❑ Dementia	❑	❑ Allergies
❑	❑ Adrenal Fatigue	❑	❑ Alzheimer's	❑	❑ Indigestion
❑	❑ Heart Attack	❑	❑ Mucus Cough	❑	❑ Heartburn
❑	❑ Chronic Fatigue	❑	❑ Vertigo or Dizziness	❑	❑ Gas
❑	❑ High Blood Pressure	❑	❑ Sinus Issues	❑	❑ Bloating
❑	❑ Low Blood Pressure	❑	❑ Tennis Elbow	❑	❑ Colitis
❑	❑ Scoliosis/Lordosis/Kyphosis	❑	❑ Carpal Tunnel	❑	❑ IBS
❑	❑ Stressed/Overwhelmed	❑	❑ Neck Pain	❑	❑ Respiratory Issues
❑	❑ Varicose Veins	❑	❑ Dizziness	❑	❑ Crohn's Disease
❑	❑ Sciatica	❑	❑ Earaches	❑	❑ Multiple Sclerosis
❑	❑ Diabetes	❑	❑ TMJ/Jaw Pain	❑	❑ Osteoporosis
❑	❑ Endometriosis	❑	❑ Low Back Pain	❑	❑ Neuropathy Pain
❑	❑ Hamstring Pain	❑	❑ Migraines	❑	❑ Lupus
❑	❑ Knee Pain	❑	❑ Frequent Colds	❑	❑ Parkinson's Disease
❑	❑ Ankle Pain	❑	❑ Dry/Runny/Itchy Eyes	❑	❑ Rheumatoid or Osteo
❑	❑ Heel Pain	❑	❑ Impaired Vision	❑	❑ Arthritis
❑	❑ Hip Pain				

If applicable, please list date(s), location(s) and/or type:

Blood Clots _____

Broken Bones _____

Cancer _____

Concussion _____

Contagious Conditions _____

Fusions _____

Heart Attack _____

Heart Disease _____

Implants _____

Limited Range of Motion _____

Sprains _____

Stroke _____

Tendinitis _____

Whiplash _____

Women: Are you Pregnant? ❑ Yes ❑No Due Date: _____

Session 1 - Date:

Your assessments:

Procedures used:

Post Treatment Comments/observations:

Session 2 - Date:

Client's comments: progress/changes observed since last session:

Procedures used:

Post Treatment Comments/observations: