Le Soleil Health & Wholeness Client Treatment Intake Form

Contact and Personal Information

Name: ____ M / F

Phone (Home): _________________ (Cell): _________________ (Work): __________________

Address: ____

City: ____ Postal Code: ___________________

Date of Birth: _______/_______/______ Occupation:_____________________________________

E-mail: ____

Do you wish to receive our newsletter and be kept up to date with events & Promotions? Y / N

Have you received this type of treatment before? Y / N

Are you currently receiving treatment(s) from other health care professionals? Y / N

If YES, please identify type of health care professional and what condition you are being treated for?

____

Family Physician:____________________________ Location: ____________________________

Emergency Contact (Name/Phone): ____

Are you currently, or have you ever received treatment for any of the following conditions:

Cardiovascular ❏ High Blood Pressure ❏ Low BLood Pressure ❏ Chronic Congestive Heart Failure ❏ Heart Attack ❏ Phebitis/Varicose Veins ❏ Stroke/CVA ❏ Family history of any of above	**Infections** ❏ Hepatitis ❏ Skin Conditions (including Warts, Atheletes foot etc) ❏ HIV ❏ Herpes ❏ Tuberculosis	**Head & Neck** ❏ Headaches/Migranes ❏ Hearing Loss ❏ Vision Problems ❏ Vision Loss ❏ Ear Problems ❏ Dizziness ❏ Family history of any of above
Cancer ❏ Currently living with ❏ Past diagnosis Type of Cancer __________________ ______________________________ Date of Diagnosis:________________	**Allergies** ❏ Please list allergies ______________________________ ______________________________ **Have you previously had any type of anaphalactic allergic reaction?** Yes/ No	**Other Conditions** ❏ Epilepsy ❏ Loss of Sensation ❏ Diabetes ❏ Autoimmune Disease ❏ Arthritis
Respiratory ❏ Chronic Cough ❏ Shortness of Breath ❏ Bronchitis ❏ Asthma ❏ Emphysema ❏ Family history of any of above	**Women** ❏ Pregnancy ___________WKS ❏ Complications ______________________________ ______________________________ ______________________________	Please list any other medical conditions not listed above, that you are currently living with or have dealt with in the past. __________________________ __________________________ __________________________

Are you presently on any medications or supplements (including pain relief) Y / N If yes please list:________

____

Please list any accidents, injuries, trauma in the past five years Y / N If Yes Please list:_________________________

____

Any surgeries in past five years? Y / N If yes please list:____

____

Any implants, internal pins, wires, artificial joints or special equipment? Y / N If yes please list:_______________

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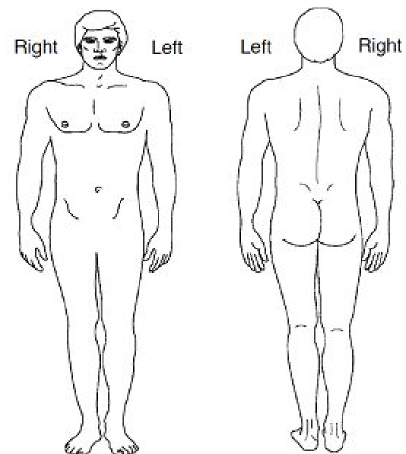
Please note that all information provided will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

I have informed the Therapist/Practitioner of all my known physical conditions, medical conditions and medications and I will keep the Therapist/Practitioner updated on any changes to my health history.

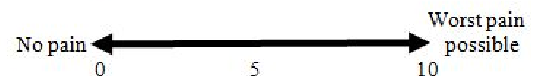
The Therapist/Practitioner explained to me and I understand:

- the general benefits of treatment
- possible treatment contraindications
- the treatment procedure
- that treatment is not a substitute for medical treatment of medications
- that it is recommended that I work concurrently with my Primary Caregiver for any conditions I may have
- that a Therapist/Practitioner does not diagnose illness or disease and does not prescribe medications

Use this diagram to indicate areas where you have your pain.



Pain Intensity:
Please use the pain scale described below to rate your pain for the questions below:



Your comfort and trust in this practice is very important to us. You are strongly encouraged to communicate with your therapist before, during & after your treatment about any aspect of the treatment.
I have read understood and completed, to the best of my knowledge, the Client History Form.
I release the Therapist /Practitioner/Summit from any and all liability from problems arising from the treatment as a result of information not given or incorrectly given in this client history.
By signing this documentation you are allowing our therapists to access to any previous and future appointment information for the benefit of aiding your treatment plan.

Client Signature: ____ Date: _________________________