Le Soleil Health & Wholeness Massage Therapy Client Treatment Intake Form

Contact and Personal Information

Name: _____ Gender:_____

Phone (Cell): _____ (Alternate Contact #): _____

Address: _____

City: _____ Postal Code: _____

Date of Birth: _____/_____/_____ Occupation:_____

Emergency Contact (Name/Phone): _____

E-mail: _____

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

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

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

_____

Family Physician:_____ Location: _____

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

Cardiovascular

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Phlebitis/Varicose Veins
- ❑ Family history of any of above
- ☐ Heart Attack
- ☐ Chronic Congestive Heart Failure
- ☐ Stroke/CVA

Infections

- ❑ Hepatitis
- ❑ Herpes
- ❑ Skin Conditions (including Warts, Athlete's foot etc)
  Please indicate type & location of skin condition:_____
- ❑ Other:_____
- ☐ HIV
- ☐ Tuberculosis

Cancer

- ❑ Currently living with
- ❑ Past diagnosis Date of Diagnosis:_____
  Type of Cancer _____

Respiratory

- ❑ Chronic Cough
- ❑ Asthma
- ❑ Emphysema
- ❑ Covid 19 - Date of diagnosis:_____
- ❑ Family history of any of above
- ☐ Shortness of Breath
- ☐ Bronchitis

Allergies

- ❑ Please list allergies_____
  Have you previously had any type of anaphylactic allergic reaction? Yes/ No

Other Conditions

- ❑ Epilepsy
- ❑ Autoimmune Disease
- ❑ Loss of Sensation
  Please indicate location(s):_____
- ❑ Tingling/Numbness
  Please indicate location(s):_____
- ❑ Pregnancy _____WKS
  Please provide details of complications:_____
- ☐ Diabetes
- ☐ Arthritis
- ☐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 **Y / N** If Yes Please list:_____

_____

Any surgeries? **Y / N** If yes please list:_____

_____

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

_____

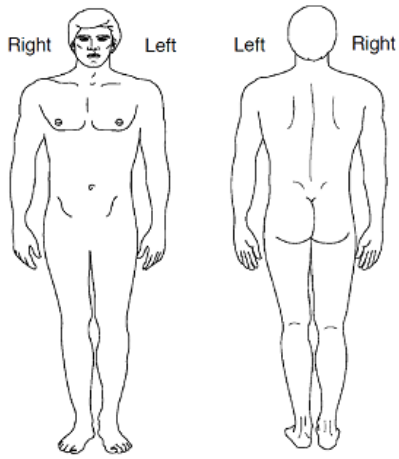
Please note that all information provided will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

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.

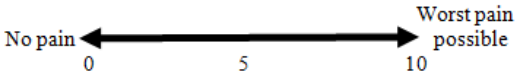
The Therapist/Practitioner explained to me and I understand:

- 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 access to any previous and future appointment information for the benefit of aiding your treatment plan.

Client Signature: _____ Date: _____

Cancellation Policy: In order to offer the best service to clients who may be in need of treatment, a 24 hour cancellation policy has been implemented. Any appointments with less then 24 hours notice of cancellation, may be subject to a cancellation fee (not to exceed the cost of the missed treatment) at the discretion of the therapist.

I am aware of and agree to abide by this cancellation policy _____ (please initial here)