RIVER STONE
Wellness Centre

Date _____

# AESTHETIC SHOCKWAVE

Confidential Patient Case History Form

Name: _____ Occupation: _____ Gender: _____

Address: _____ City: _____ Postal Code: _____

Email: _____ Age:____ Birthdate: (Day)_____ (Month)_____ (Year)_____

AB Health Care #: _____ Home Phone: _____ Cell Phone: _____

Medical Doctor: _____ Doctor Phone #: _____

Emergency Contact Name: _____ Phone #: _____

How did you hear about us? (check one below)

❒ Google ❒ Facebook ❒ Instagram ❒ Storefront Sign ❒ River Stone Therapist: _____

❒ World Weight Loss Inc. ❒ Doctor or lawyer: _____ ❒ Other: _____

I agree that River Stone Massage may notify me of new treatments and promotions via email. ❒ Yes ❒ No

**Cardiovascular**
❒ High blood pressure
❒ Low blood pressure
❒ Chronic congestive heart failure
❒ Heart attack
❒ Phlebitis / varicose veins
❒ Stroke / CVA
❒ Pacemaker or similar device
❒ Heart disease
❒ Dizziness / vertigo
❒ Seizures
❒ Blood clots

Is there a family history of any of the above? ❒Yes ❒No

**Head and Neck**
❒ History of headaches
❒ History of migraines
❒ Vision problems
❒ Vision loss
❒ Ear problems
❒ Hearing loss

**Women**
❒ Pregnancy
*Due Date:* _____
❒ Previous Pregnancy Complications:
*Describe:* _____
❒ Menopausal problems:
*Describe:* _____
❒ Menstrual problems:
*Describe:* _____
❒ Gynecological conditions
*Describe:* _____

**Respiratory**
❒ Asthma
❒ Bronchitis
❒ Emphysema
❒ Chronic Cough
❒ Shortness of breath

Is there a family history of any of the above? ❒ Yes ❒ No

**Muscle/Joint**
❒ Neck
❒ Back (❒ lower ❒ mid ❒ upper)
❒ Shoulders
❒ Elbow
❒ Wrist / Hand
❒ Hip
❒ Knee
❒ Ankle / Foot
❒ Spine

**Infectious Conditions**
❒ Skin Conditions
*Describe:* _____
❒ Respiratory Conditions
*Describe:* _____
❒ Hepatitis

**Skin Conditions**
❒ Eczema
❒ Psoriasis
❒ Rash
❒ Warts
❒ Open Sores

**Digestive**
❒ Constipation
❒ Crohn's Disease
❒ Colitis
❒ Irritable Bowel Syndrome
❒ Ulcers

**Other**
❒ Loss of sensation
*Where?* _____
❒ Diabetes
*Onset:* _____
*Type:* _____
❒ Allergies / hypersensitivity
*What?* _____
❒ Epilepsy
❒ Cancer
*Type/Location:* _____
❒ Arthritis
*Type/Location:* _____
❒ Hemophilia
❒ Fibromyalgia
❒ Chronic fatigue
❒ Scoliosis
❒ Polio / Post Polio
❒ Osteoporosis
❒ Thyroid Problems

Is there a family history of any of the above? ❒ Yes ❒ No

**Men**
❒ Enlarged Prostate
❒ Libido Issues
❒ Other
_____

**Do you have any medical conditions not listed above?** ❒ Yes ❒ No

*If yes, please describe:* _____

_____

**Do you have any internal wires, artificial joints, pacemakers or special equipment that we should be aware of?**

❒ Yes ❒ No *If yes, please describe:* _____

_____

**Briefly list any surgeries you have had:** _____

_____

**Has you weight changed significantly in the past 2 years?** ❒ Yes ❒ No

**Are, or were, you a smoker?** ❒ Yes ❒ No

**Do you sleep well?** ❒ Yes ❒ No

**How often do you exercise**? ❒ Daily ❒ Often ❒ Rarely ❒ Almost never

**Please rank your stress levels:** ❒ Low ❒ Medium ❒ High ❒ Very High

**Do you experience:** ❒ Food Allergies/Intolerances ❒ Indigestion ❒ Constipation ❒ Acid Reflux

**Do you have any dietary deficiencies, such as anemia or low vitamin D?** ❒ Yes ❒ No

*If yes, please describe:* _____

**Briefly explain any health concerns/issues you may have related to the treatment:**

_____

_____

**Are you presently taking any prescribed medication(s)?** ❒ Yes ❒ No

*If yes, please note the medication(s) and the condition(s) for which it is being used if known.*

_____

_____

**I acknowledge that no assurance or guarantee has been provided as to the results of the treatment. I understand that the Practitioner must be fully aware of my existing medical conditions. I have completed my medical history form as provided by River Stone and disclosed all of those medical conditions affecting me. It is my responsibility to keep the Practitioner updated on my medical history. I give consent for my treatment notes to be read by the other health care professionals at River Stone. The information I have provided is true and complete to the best of my knowledge.**

**Cancellation:**
**We require 24 hours' notice if you need to cancel/change your appointment so that we may accommodate another client in need of our services. If you cancel with less than 24 hours' notice, a $50.00 cancellation fee will be charged to your account and/or credit card. We hold encrypted credit card information on our secure server.**

_____ _____ _____

Signature Date Practitioner Signature