RIVER STONE
Wellness Centre

Date _____

FASCIAL STRETCH THERAPY

Confidential Patient Case History and Consent 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

Please indicate conditions you are experiencing or have experienced:

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
❒ Back or pelvic hypermobility

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:* _____

_____

Have you had recent X-rays and if so what were the findings?

_____

_____

How long have you experienced this pain? ❒ Years ❒ Months ❒ Weeks

Is this your first episode of this pain? ❒ Yes ❒ No

Are you pregnant?	❒ Yes ❒ No
Have you recently had surgery?	❒ Yes ❒ No
Do you have any hypermobility (excessive flexibility) in the back or pelvis?	❒ Yes ❒ No
Do you have any herniated or bulging discs in your back?	❒ Yes ❒ No
Do you have an acute injury or infection?	❒ Yes ❒ No
Do you have active, painful osteoarthritis?	❒ Yes ❒ No

I acknowledge that no assurance or guarantee has been provided as to the results of the treatment. I understand that the Therapist 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 Therapist 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 therapeutic 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 Therapist Signature