SOUTH 143, 14919 Deer Ridge Dr. SE, Calgary T2J 7C4
Tel: 403.455.8029 **Email:** south@holisticinstitute.ca

NORTH 150, 4411 16th ave NW Calgary, AB T3B 0M3
Tel: 403.984.3970 **Email**: north@holisticinstitute.ca

MASSAGE/CRANIOSACRAL THERAPY

FERTILITY

Patient Information

Date: ______________________________

Preferred Name: ________________________ Last Name:____

Date of Birth (M/D/Y): ________________ Age: _________ Gender Pronoun:

Address:____

City: _______________________ Province :_________ Postal Code: __________________

Phone: (1) __________________________ (2) _____________________________ Email ______________________________

Referral Information

Personal referral: ______________________________

(circle) Doctor/physiotherapist/acupuncturist/massage therapist/yogi/midwife/doula referral:

(name of) ____

Health Care Providers

Family Doctor (name of): ____

OBGYN (name of): ____

(circle) Massage Therapist / Acupuncturist / Naturopath / Chiropractor / Physiotherapist

(name of) ____

Other Care Providers: __________________________________ _______________________________________

SOUTH 143, 14919 Deer Ridge Dr. SE, Calgary T2J 7C4
Tel: 403.455.8029 **Email:** south@holisticinstitute.ca

NORTH 150, 4411 16th ave NW Calgary, AB T3B 0M3
Tel: 403.984.3970 **Email**: north@holisticinstitute.ca

GYNAECOLOGICAL / REPRODUCTIVE HISTORY			
Birth control?	☐ Yes ☐ No	How long?	Type?
Age of first period?		Date of your last period?	
Duration of period? (days)		Length of cycle? (days)	
Are cycles regular? ☐ Yes ☐ No		Painful menses?	☐ Yes ☐ No
How heavy is your bleeding?		☐ Light ☐ Normal ☐ Heavy	
What color is the blood?	☐ Light red ☐ Red ☐ Dark Red ☐ Purple ☐ Brown ☐ Black		
Is there clotting? If yes, are they		☐ big clots ☐ small clots ☐ tissue	
Do you bleed or spot in between periods?		☐ Yes ☐ No	
Are you pregnant, if "yes" how many weeks?		☐ Yes ☐ No Number of weeks_____________	
Do you have a midwife, OBGYN, Doula? (Circle one)	☐ Yes ☐ No	Breast pain, lumps?	☐ Yes ☐ No
Endometriosis?	☐ Yes ☐ No	Cervical Dysplasia?	☐ Yes ☐ No
Ovarian cysts, fibroids?		☐ Yes ☐ No	
How many children to do have?		Number:	Years:
How many pregnancies have you had?		Number:	Years:
How many abortions have you had?		Number:	Years:
How many miscarriages have you had?		Number:	Years:
How many times has a D&C been performed?		Number:	Years:
Have you ever had an abnormal pap smear?		☐ Yes ☐ No	
Have you ever had a venereal disease?		☐ Yes ☐ No	
Do you get yeast infections regularly?		☐ Yes ☐ No	
Have you ever had pelvic inflammatory disease?		☐ Yes ☐ No	
Have you ever been diagnosed with any pelvic abnormalities?			☐ Yes ☐ No
Do you get premenstrual back pain?			☐ Yes ☐ No
Do your bowel movements become loose at the beginning of your period?		☐ Yes ☐ No	
Menopausal symptoms?		☐ Yes ☐ No	

HOLISTIC INSTITUTE OF
Health & Fertility

SOUTH 143, 14919 Deer Ridge Dr. SE, Calgary T2J 7C4
Tel: 403.455.8029 **Email:** south@holisticinstitute.ca

NORTH 150, 4411 16th ave NW Calgary, AB T3B 0M3

Family History

Is there a **history in your family** of (circle) cancer/ diabetes/ heart attack/ high blood pressure/ stroke/ arthritis/ neck/back pain
(indicate ailment) Father__________Mother____________Siblings____________Grandparents:_________

SYSTEMS REVIEW: Please **CHECK** any of the following conditions you are experiencing **currently** and **UNDERLINE** those you have experienced in the **past**:

GENERAL SYMPTOMS
- Fever
- Sweats
- Fainting
- Sleep disturbance
- Fatigue
- Nervousness
- Weight loss
- Weight gain

NEUROLOGICAL
- Visual disturbance
- Dizziness
- Fainting
- Convulsions
- Headache
- Numbness
- Neuralgia (nerve pain)
- Poor coordination
- Weakness

MUSCLE & JOINT
- Neck pain
- Low back pain
- Arm pain
- Shoulder pain
- Leg pain
- Knee pain
- Foot pain
- Pain/numbness in arms/legs
- Pain between shoulders
- swollen joints
- Spinal curvature
- Arthritis
- Fractures

RESPIRATORY
- Chronic cough
- Spitting up phlegm
- Spitting up blood
- Chest pain
- Wheezing
- Difficulty breathing
- Asthma

CARDIOVASCULAR
- Rapid beating heart
- Slow beating heart
- High blood pressure
- Low blood pressure
- Pain over heart
- Hardening of arteries
- Swollen ankles
- Poor circulation
- Palpitations
- Cold hand or feet
- Varicose veins

EARS/EYES/NOSE/THROAT
- Eye pain
- Double vision
- Ringing in ears
- Deafness
- Nosebleeds
- Trouble swallowing
- Hoarseness
- Sinus infection
- Nasal drainage
- Enlarged glands

GENITOURINARY
- Frequent urination
- Painful urination
- Blood in urine
- Pus in urine
- Kidney infection
- Prostate trouble
- Uncontrollable urine flow

GASTROINTESTINAL
- Poor appetite
- Difficult digestion
- Heartburn
- Ulcers
- Nausea
- Vomiting
- Constipation
- Diarrhea
- Blood in stool
- Gallbladder/jaundice
- Colitis/Crohn's

FOR WOMEN ONLY
- Painful menstruation
- Hot flashes
- Irregular cycle
- Cramps or back pain
- Vaginal discharge
- Nipple discharge
- Lumps in breast
- Menopausal symptoms
- Birth control pills
- Miscarriages
- Complications with pregnancy

SOUTH 143, 14919 Deer Ridge Dr. SE, Calgary T2J 7C4
Tel: 403.455.8029 **Email:** south@holisticinstitute.ca

NORTH 150, 4411 16th ave NW Calgary, AB T3B 0M3
Tel: 403.984.3970 **Email**: north@holisticinstitute.ca

HIHF CLINIC CANCELLATION POLICY

We understand at the Holistic Institute of Health and Fertility (HIHF) that unplanned events can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance.

We want to be available for your needs and the needs of all our clients. When a client does not show up for a scheduled appointment, another client loses an opportunity to be seen. In the event of a missed appointment or an appointment cancelled within less than 24 hours notice, you will be charged the **FULL FEE.**

MasterCard, Visa and American Express are accepted at the clinic. Your credit card number will be kept on file to book/hold your appointment. Your credit card will only be charged should an appointment be missed without notifying the HIHF clinic.

Please indicate your acceptance of this policy by signing below. You are a valued patient, thank you for your understanding and cooperation.

Signature: ______________________ Printed Name: ______________________

Date: ______________________

Signature of Parent or Guardian if the Patient is under 18 years of age: ______________________

HIHF CLINIC WAIVER

I understand that I should be evaluated by a physician for the condition I am requesting consultation. The diagnosis and treatment plan I will be given by the Holistic Institute of Health and Fertility (HIHF) is based on traditional Chinese medicine, and/or therapeutic massage, and/or yoga principles only and does not constitute a Western Medical diagnosis. I understand that I am not to rely on these therapeutic diagnosis and treatments as my sole remedy for the treatment I am seeking. I understand there may be some minor risks associated with these therapies including but not limited to slight bleeding, bruising, and mild dizziness. I understand clinic staff may review my records but all information will be kept confidential and will not be released without my written consent. If no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a Western Medical doctor. Further, if I am concurrently undergoing Western Medical treatments, it is my responsibility to advise my physician of any of these therapies and/or herbal supplements I am concurrently taking. I assume all risks and responsibilities for myself and release HIHF clinic and its agents from any injury or liability that may occur during a treatment session.

Please sign and date below to indicate that you have read and understood this form.

Signature: ______________________ Printed Name: ______________________

Date: ______________________

Signature of Parent or Guardian if the Patient is under 18 years of age: ______________________