



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
Tel: 403.984.3970 Email: north@holisticinstitute.ca

MASSAGE/CRANIOSACRAL THERAPY

GENERAL INTAKE

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: _____



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Patient Health History

Reason for this appointment/major complaint: _____

When did your condition begin: _____ (circle) days /weeks /months/years

Have you had this condition before: Y/N

Is your condition getting (circle): Better/ Worse/ No change

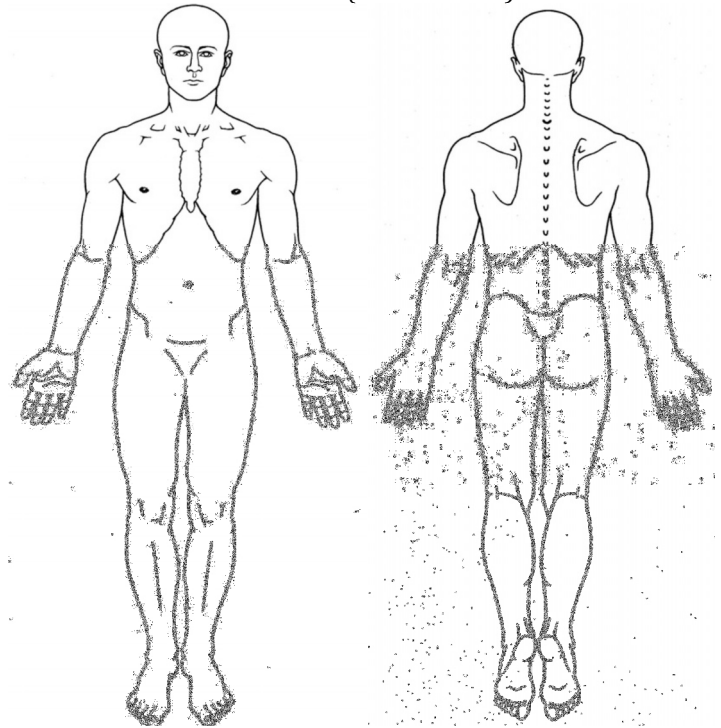
Symptoms came on (circle): Suddenly/ Come & Go

Indicate the **severity** of the **pain** by circling one of the following numbers:

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Extreme Pain)

*Please use the symbols below to mark on the pictures where you are experiencing your current pain.

Numbness	===
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	///
Pins, Needles	+++
Other _____	^^^



Describe the character of your pain (circle): dull & achy, sharp/stabbing, shooting, throbbing

What activities make this condition better? (circle): ice, heat, stretching, resting

What activities make this condition worse? (circle): activity, certain movements, prolonged standing/sitting

Have you experienced radiating pain/ numbness/ tingling/ weakness since your condition began?

If so please specify where: _____



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/Chrohns

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



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 with at least 24 hours notice.

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: _____