Lindsay Rose Holistic Health

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Client Intake & Health Form

Last Name: ______________________________ First Name: ____________________________
Address: ____Postal Code:__________________
Primary Phone: ________________ Day Phone: ______________ Cell #: _________________
Occupation: __________________ How did you hear about me?: _______________________
Date of Birth:____________________ Email: ____

What is your 1st major condition you want to improve?
____
____

When did you first notice this? ____
What brought it on? ____
What activities aggravate the condition? ____
Is this condition getting progressively worse? ❑ Yes ❑ No
Please explain
____

Does this condition interfere with:
Work? ❑ Yes ❑ No Sleep? ❑ Yes ❑ No Daily Routine? ❑ Yes ❑ No
Please explain
____
What have you done to get relief? ____
Has there been a medical diagnosis? ❑ Yes ❑ No – Results ______________________________

What is your 2nd condition you wish to improve?
____
____

When did you first notice this? ____
What brought it on? ____
What activities aggravate the condition? ____
Is this condition getting progressively worse? ❑ Yes ❑ No
Please explain ____
Does this condition interfere with:
Work? ❑ Yes ❑ No Sleep? ❑ Yes ❑ No Daily Routine? ❑ Yes ❑ No
Please explain ____
What have you done to get relief? ____
Has there been a medical diagnosis? ❑ Yes ❑ No – Results ______________________________

What are your intentions and expectations for this visit? ______________________________
____

What other therapies have you received? ❑ Massage ❑ Acupuncture ❑ Chiropractic
❑ Hypnotherapy ❑ Energy / Chakra Healing ❑ Shiatsu ❑ Bowen ❑ Reiki
❑ Physiotherapy ❑ Other (list) ____

Health History

Check the following conditions that apply to you, past and current.
Key: P = Past and C = Current
Please add your comments to clarify the condition.
Name: ____

General Conditions

- ❑ Fatigue
- ❑ Headaches
- ❑ Migraines
- ❑ Depression – How Long?_____
- ❑ Weakness
- ❑ Insomnia
- ❑ Excessive Heat
- ❑ Excessive Cold
- ❑ Sensitivity to Light
- ❑ Chronic Pain
Where_______________
- ❑ Lack of Concentration
- ❑ Cancer________________
Treatments________________
- ❑ Contagious Disease
- ❑ Other_________________

Comments:

Muscular / Skeletal

- ❑ Joint Stiffness / Swelling
- ❑ Spasms / Cramps
- ❑ Strains / Sprains
- ❑ Broken / Fractured Bones
- ❑ Dislocations
- ❑ Tendonitis
- ❑ Bursitis
- ❑ Arthritis
- ❑ Scoliosis
- ❑ Osteoporosis
- ❑ Bone / Joint Disease
- ❑ Chest / Rib Pain
- ❑ Shoulder / Neck Pain
- ❑ Back Pain
- ❑ Arm / Hand Pain
- ❑ Leg / Foot Pain
- ❑ Other_________________

Comments:

Neurological / Throat /Skin

- ❑ Dizziness
- ❑ Concussions - # ______
- ❑ Eye / Vision problems
- ❑ Poor hearing
- ❑ Ringing in ears
- ❑ Head Trauma
- ❑ Skin Sensitivities
- ❑ Eczema
- ❑ Psorias
- ❑ Acne
- ❑ TMJ/Jaw problems
- ❑ Grinding teeth
- ❑ Throat infections
- ❑ Cosmetic Surgery
- ❑ Rashes
- ❑ Athlete's Foot
- ❑ Warts
- ❑ Abnormal Moles
- ❑ Other_________________

Comments:

Cardiovascular

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Pace maker
- ❑ Diabetes
- ❑ Chest pain
- ❑ Irregular heart beat
- ❑ Bruise / Bleed easily
- ❑ Blood Clots
- ❑ Fainting
- ❑ Dizziness
- ❑ Sweats / Chills / Fever
- ❑ Stroke_____________
- ❑ Lymphedema
- ❑ Varicose veins
- ❑ Heart Condition
- ❑ Other _______________

Comments:

Respiratory

- ❑ Asthma
- ❑ Shortness of breath
- ❑ Chronic cough
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Lung Cancer
- ❑ Pneumonia
- ❑ Sinus Discomfort
- ❑ Excess Mucous
- ❑ Allergies _____________
- ❑ Other _______________

Comments:

Digestive and Uro-Genital

- ❑ Liver / Gall Bladder
- ❑ Gall stones
- ❑ Kidney
- ❑ Kidney stones
- ❑ Venereal disease
- ❑ Abdominal Pain
- ❑ Indigestion / Reflux
- ❑ Excess Gas / Bloating
- ❑ Colitis
- ❑ Crohn's Disease
- ❑ Diverticulitis
- ❑ Adaptive Aids
- ❑ Elimination #___Daily
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nervous Stomach
- ❑ Irritable Bowel
- ❑ Poor / Heavy Appetite
- ❑ Cravings ______________
- ❑ Urination # _____daily
- ❑ Urination Discomfort
- ❑ Bladder Infection
- ❑ Impotence
- ❑ Other _________________

Comments:

Gynecology

- ❑ Pregnant (# of months____)
- ❑ Miscarriages - # _____
- ❑ Menopause – Age ____
- ❑ PMS / Cramps
- ❑ Pelvic Inflammation
- ❑ Fertility Concerns
- ❑ Breast lumps/cysts
- ❑ Uterus cysts
- ❑ Endometriosis
- ❑ Prostate Concerns (Men)
- ❑ Hysterectomy – Date ____
- ❑ Other _________________

Comments:

Nervous System

- ❑ Spinal Injury
- ❑ Sciatica
- ❑ Fractures/Breaks of spine
- ❑ Herniated Disc
- ❑ Fibromyalgia
- ❑ Seizures / Epilepsy
- ❑ Tremors
- ❑ Parkinson's Disease
- ❑ Cerebral Palsy
- ❑ Stroke
- ❑ Numbness
- ❑ Twitching
- ❑ Tingling
- ❑ Paralysis – constant or temporarily
- ❑ Muscular Dystrophy
- ❑ Multiple Sclerosis
- ❑ Neurological Conditions
Type____________________
- ❑ Other__________________

Comments:

Are you presently on any medications? (Please list and give reason) ___________________________

Have you had any injuries, accidents or surgery? (Type, Date & Direction of impact if applicable)
1.____
2.____
3.____

Is this an ICBC or WCB claim? Yes No
(only applicable when working with a Registered Massage Therapist)

What is your stress level? Slight ___ Moderate ___ High ____
What is the source(s) of your stress? ____

What is your level of physical activity? ___ None ___ Low ___Moderate ___ High

In a standard treatment, the full body is worked on with the exception of breasts and genitals.
Please list any other areas of your body you do not want touched or worked on ___________________

Client Consent

I have reviewed, understand and agree to the information about Policies and Procedures, Confidentiality and Privacy Policies explaining how Lindsay Rose Holistic Health will use my personal information, and the steps that are taken to protect my information and confidentiality. I agree that Lindsay Rose Holistic Health can use and disclose personal information about me as set out in the Privacy Policies.

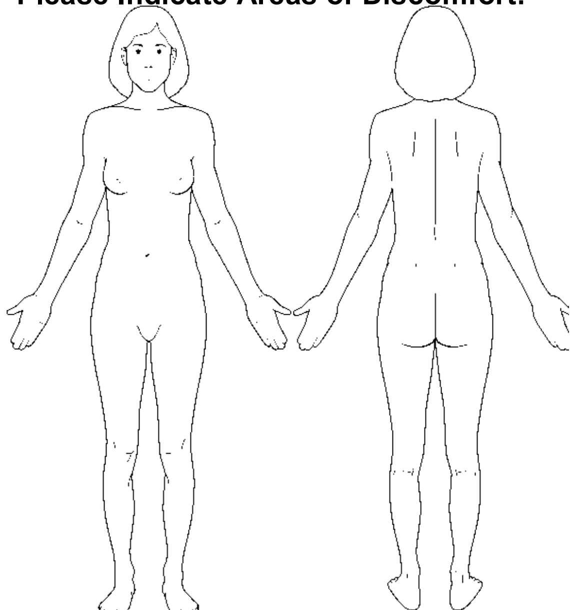
By my signature below, I understand that holistic therapy is not a substitute for medical treatment and that it is recommended that I concurrently work with my Primary Caregiver / Physician for any condition I may have. I am aware that holistic practitioners or massage therapists do not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of holistic therapy.

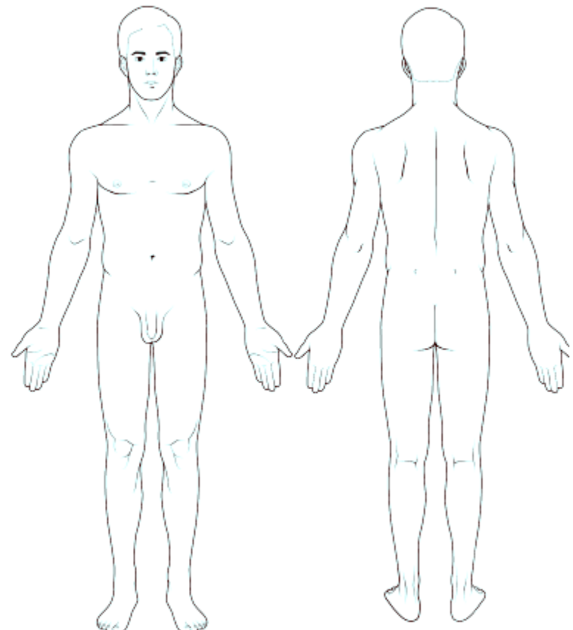
I have informed Practitioner or Therapist of all my known physical conditions, medical conditions and medications, *and I will keep Lindsay Rose Holistic Health updated on any changes*.

By my signature below, I consent to treatment and certify that the information I have provided is accurate. I also understand that failure to provide full or false information may result in an incorrect treatment approach.

_____________________ ________________________________
Date Signature

Please Indicate Areas of Discomfort:





POLICIES AND PROCEDURES

Medical Health Conditions:
Holistic therapy is not a substitute for medical treatment and it is recommended that you work concurrently with a physician or primary caregiver for any health conditions. Therapists and Practitioners at Lindsay Rose Holistic do not diagnose illness or disease and do not prescribe medications.

Payment for Services:
Payment for service is due at the end of each visit for individual sessions. Fees may be paid by cash, cheque or online with a credit card or PayPal. For Programs, credit card or post dated cheques will be accepted if paying in installments. A receipt will be given when payment is received.

Arriving Late, Cancelled and Missed Appointments:
Visits that begin late due to late arrival will still end at the scheduled time. Please ensure to give at least 12 hours cancellation notice. Appointments cancelled on the same day or missed appointments, a $20.00 fee may be charged. Consideration will be given to unforeseeable circumstances.

LINDSAY ROSE HOLISTIC HEALTH CONFIDENTIALITY & PRIVACY POLICY

Everything that you communicate, directly or indirectly, at Lindsay Rose Holistic Health is confidential, unless you give written permission to disclose information to an outside third party.

There are exceptions to confidentiality that include the legal and/or ethical obligations to:
1. Report incidents of child abuse (physical, sexual or emotional) and neglect;
2. Comply with a court ordered subpoena;
3. Prevent harm to yourself or another person should such plans be disclosed;
4. Report a health professional who has sexually abused a patient.

Protecting the privacy of your personal information, while at the same time providing you with quality holistic health care, is an important part of the business practices by everyone who works at Lindsay Rose Holistic Health. We understand the importance of protecting your personal information and are committed to collecting, using and disclosing your personal information responsibly. The health file that you create is completely confidential within Lindsay Rose Holistic Health and not shared with outside sources, unless you request otherwise by signing a consent form for the release of records.

The privacy policy outlines what Lindsay Rose Holistic Health does to ensure that:
• Only necessary information is collected about you; Information is only shared with your consent; Storage, retention and destruction of your information comply with existing legislation, and privacy protection protocols.

How Lindsay Rose Holistic Health Collects, Uses and Discloses Client's Personal Information

• To assess your health concerns and provide holistic health care and treatment
• To advise you of session options or with therapist/practitioner referral options
• To provide follow-up contact and care
• To establish and maintain contact with you via appointment reminders, newsletters and updates
• To process credit card payments if applicable
• To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others

By signing the Client Consent section of the intake form, you agree to give your consent to the collection, use and/or disclosure of your personal information as outlined above.