KerstinLindsay

Pain Management & Tissue Repair

Name: _____ **Date:** _____

Adress: _____ **Postcode:** _____

PH: _____ **Mob:** _____ **Email:** _____

Date of Birth: _____ **Age:** _____

Marital Status: _____ **Children:** _____

Occupation:_____

Emergency Contact: _____ **Ph:** _____

Doctor: _____ **Health Fund:** _____

How did you hear about the clinic? _____

1) What is concerning you today?

_____

_____

2) What would you like to get out of your session/s today and in the future?

_____

3) Current medications and/or supplements:

_____

_____

4) List other therapies besides conventional medicine in which you are currently participating:

_____

5) Have you had any illnesses, accidents, surgeries, allergies or broken bones in the past:

_____

_____

6) For women, are you pregnant? Yes / No **If yes, how far along?** _____

Family History:

Health conditions: e.g. asthma, heart disease, diabetes, high cholesterol, stroke, osteoporosis, cancer, depression, anxiety, hepatitis, glandular fever etc.

Mother: _____ Father: _____

Brothers: _____ Sisters: _____

Grandfathers: _____ Grandmothers: _____

Uncles:_____ Aunties: _____

7) Your Medical History:

- ☐ Asthma
- ☐ Thyroid disorders
- ☐ Depression
- ☐ Anxiety
- ☐ Eczema/dermatitis/psoriasis
- ☐ Hepatitis
- ☐ Glandular fever
- ☐ Appendicitis/removal
- ☐ Pneumonia
- ☐ Ear infections/grommets
- ☐ Tonsillitis/removal
- ☐ Gallstones/gall bladder removal
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Stroke/blood clots
- ☐ Bowel problems
- ☐ Diabetes
- ☐ Urinary infections
- ☐ Previous cancer
- ☐ Pregnancies, number:
- ☐ Any complications?
- ☐ Preterm baby
- ☐ Miscarriage/s
- ☐ Toxema
- ☐ Gestational diabetes
- ☐ Other

I attest that the above information is true and accurate to the best of my knowledge

Signature: _____Date: _____Therapists Initials: _____

If minor, signature of guardian required: _____ Date: _____

Disclaimer: By signing above, I agree that I understand that a naturopath is not a doctor and cannot prescribe medication or diagnose medical conditions.

INFORMED CONSENT TO LOW LEVEL LASER TREATMENT

I hereby consent for my therapist to treat me with low level laser therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist. I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks. I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge. I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers. I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Client Name _____ Signature of Client/Guardian _____
Date Signed _____