



Name _____ Phone: _____ Cell: _____
 Address: _____
 Sex: M F Age: ____ Date of Birth: ____/____/____ Height: ____-____ Weight: ____ lbs
 Email: _____ Today's Date ____/____/____
 Occupation: _____ Referred by: _____
 Emergency Contact: _____ Relationship: _____
 Phone: _____ Cell: _____ Family Doctor _____

Have you had previous bodywork?
 General massage Chiropractic Physiotherapy Cranial Sacral Other: _____

Have you ever had a condition that prevented you from having massage, either locally or systemically?
 No Yes (explain) _____

What is your specific problem today? _____

Have you been to see your Family Doctor for this current issue? No Yes _____

What is the intensity of your symptoms?
 Burning Sharp pain Muscle Spasm Cold hands or feet
 Numbness Cramping Radiating heat
 Tingling Dull Pain

When did your symptoms start and under what circumstances?
 Motor vehicle accident
 Repetitive strain such as lifting or office work
 Workplace accident
 Sports injury or accident
 Post-surgical procedure
 Sleeping (new bed) or getting out of bed
 Vacation related
 Bending Forward
 Falling down or slipping on ice

What makes your symptoms worsen? _____
 Walking Running Cycling
 Sitting In/Out of your car Swimming
 Sleeping getting out of bed Standing

What makes your symptoms improve? _____
 Sleeping Walking Standing Sitting Heat Ice Nothing Exercise

Medical Review and History:

This information is gathered to evaluate potential contraindications to treatment, limitations, or precautions as well as potential links of interrelatedness. Please include present and past conditions.

Heart Health/ Cardiovascular

- € Hypertension
- € Shortness of breath
- € Low blood pressure
- € High blood pressure
- € Palpitations
- € Tachycardia
- € Arrhythmia
- € Medication _____
- _____

On your body:

- € Wear contact lenses
- € Dentures
- € Hearing aid
- € Pacemaker
- € Hip / Knee replacement
- € Orthotics

Conditions

- € HIV positive
- € Hepatitis
- € Hypothyroid
- € Hyperthyroid
- € Skin infection (currently)
- € Psoriasis or eczema
- € Bruise easily
- € Corns or bunions
- € History of skin cancer
- € Significant scars

Joints or Muscle Pain:

- € Concussion history
- € Vertigo
- € Migraine headaches
- € Headaches in general
- € TMJ pain (jaw)
- € Sciatica (hip or leg pain)
- € Lower back pain or problems
- € Mid back pain or problems
- € Shoulder joint pain or problems
- € Knee joint pain or problems
- € Ankle joint pain or problems
- € Foot joint pain or problems
- € Neck joint pain or problems
- € Elbow joint pain or problems
- € Wrist / hand pain or problems
- € *Bursitis*
- € Tendonitis
- € Osteoarthritis
- € Herniated disc _____
- € Spinal/ Lumbar stenosis

Pregnancy and Birth:

- € Pregnant
- € Nursing
- € Natural childbirth (No. ____)
- € C-Section births (No. ____)
- € Complications _____
- _____

Illnesses or Disease:

- € Diabetes
- € Epilepsy
- € Phlebitis (blood clots in leg)
- € Vascular constriction
- € Fibromyalgia

Respiratory History

- € Bronchitis
- € Sinus congestion
- € Ear, Nose or throat issues
- € Allergies
- € Past smoker (Years: _____)
- € Current smoker (Years: _____)

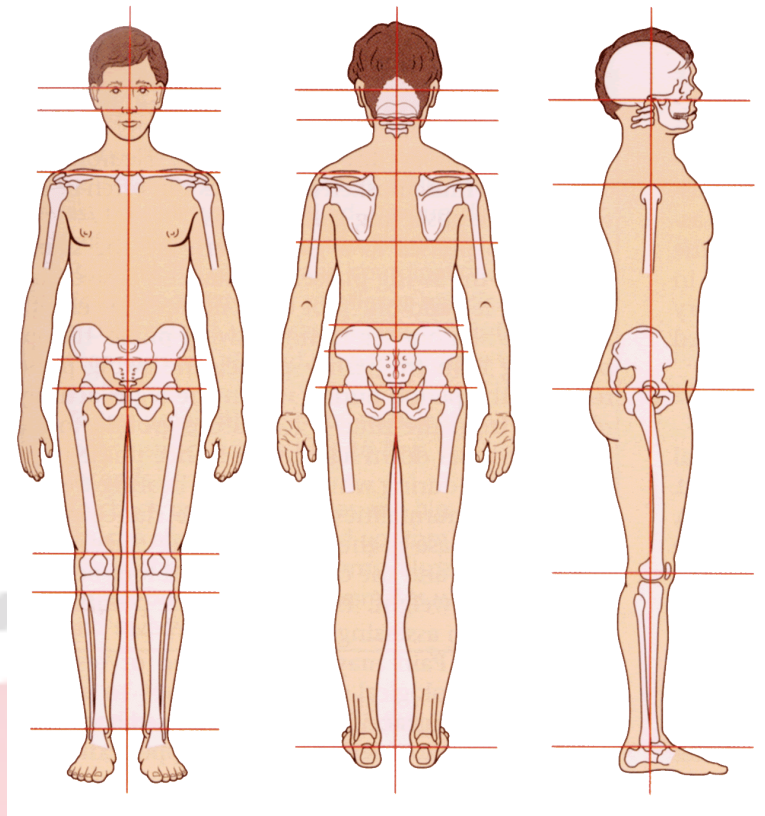
Gastrointestinal/ Digestion

- € Dysphagia/ difficulty swallowing
- € Food allergies
- € Pyrosis/ heartburn
- € Stomach ulcers
- € Crohn's disease
- € Irritable bowel syndrome
- € Slow digestion
- € Constipation
- € Hemorrhoids

Genital/ Urinary

- € Pain when urinating
- € Bladder infections
- € Incontinence
- € Sexual dysfunction
- € Endometriosis

Previous Surgeries: (include the date)**Broken bones/Fractures****Injuries & Accidents****Current medications:**



Posture:

Consent for Soft Tissue Therapy

I hereby apply for and consent to bodywork from Ivan Duben a Board Certified Structural Integration Practitioner.

I understand that these results vary from individual to individual and that no specific results can be guaranteed.

I understand that the Practitioner does not treat, prescribe for, or diagnose any illness, disease, or any other physical or mental disorder, injury, or condition. Nothing said or done by the Practitioner should be construed as such. **I further understand that the Practitioner is not attempting to practice medicine requiring a license under the laws of British Columbia.**

I understand that it is necessary for the Practitioner to touch my body in order to assist me in establishing balance and alignment in my body. I give the Practitioner my permission and consent to do all those things necessary in helping me establish balance and alignment. I give the Practitioner full privilege and license to work on my body in such a way as to restore and establish balance and alignment therein. I have been informed by the Practitioner that at any time, I may ask to stop the treatment for any reason whatsoever and that the Practitioner will immediately comply with my request. Furthermore, it is understood that the Practitioner will respect my personal comfort level with degree of undressing for each procedure, understanding that clothing may present certain restrictions for treatment.

By signing this form, my consent applies to this session and all subsequent sessions by the Practitioner. I agree to give my Practitioner at least **24 hour's notice of my cancellation of an appointment.** I fully understand that I will be charged the **full rate** for my appointment if I fail to provide 24 hour's notice. By signing this consent agreement, I am personally fully accountable and responsible for all services provided to me by Ivan Duben, regardless of insurance coverage or co-payments that may or may not apply.

Payment is expected at time of services.

Patient Name (printed) _____

Signature: _____
(Parent or legal guardian's signature, if client is a minor)

Date: ____/____/____

Parent's Name: _____
(Parent or legal guardian's name, if client is a minor)