Advanced Pain Relief

Health History Form - Minimum Requirements

Name: ______________________________ Date of Initial Visit: _____________________
Address: ____________________________ Phone Number: ________________________

Email: _______________________________

Date of birth: _______________________ Referred by: ____________________________

Physician Name: ____________________ Allergies: ______________________________

Sports & Activities: ____

Current Medications: ____

Are you under medical care for any of the following: (please circle all that apply)

heart conditions	high/low blood pressure	fainting or dizziness
varicose veins	phlebitis/circulatory problems.	headaches or migraine
neck injury	back injury	jaw or ear pain
osteoporosis	rheumatoid arthritis	osteoarthritis
cancer	kidney disease	skin conditions
diabetes	asthma/respiratory	fibromyalgia
Crohn's disease	pelvic inflammatory disease	epilepsy
nervous disorders	whiplash	other: _____________

Have you ever received care from any of the following: (please circle all that apply)

Physiotherapist Chiropractor Massage Therapist Naturopath

Other: ____

Reason for treatment: ____

Have you had surgery in the past? Y N If yes, for what? ___________________

Have you had any previous fractures/sprains? Y N If yes, where?_____________

Did the current injury result from a motor vehicle accident or workplace injury? Y N

Have you had any of the following regarding your current condition: (please circle all that apply)

physicians examination x-ray other diagnostic tests

What relieves your pain? ____

What aggravates your pain? ____

Advanced Pain Relief

Patient Consent Form

In order for us to provide treatment for your condition(s) it is necessary for you to give your informed consent. Such treatments may include electrical stimulation which has the following contraindications:

Pacemaker

Pregnancy

Epilepsy/Seizures (no treatment above the neck)

Cancer

Electrical stimulation or “e-stim” involves the use of electric devices such as TENS (Transcutaneous Electrical Nerve Stimulation), or MENS (Microcurrent Electrical Nerve Stimulation).

I have read and understand all of the above information and by signing below I consent to treatment.

I understand that I may not receive treatment until I understand this consent form and have signed it.

Patient’s Name (Print)

____

Patient’s Signature (Parent’s signature is required if the patient is under 18 years old)

____

Today’s Date:

____