SHARON PIPPUS, RENOVARE HEALTH THERAPY

608 – 86th Avenue SW Calgary, AB T2V 0V9
(403) 836-3484 ◆ sapippus@gmail.com

Date: _____

CLIENT INFORMATION

Name: _____ Gender: □ Male □ Female

Address: _____ Cell: _____

_____ Home: _____

Email: _____

Date of Birth _____ / _____ / _____ Height: _____
(d) (m) (y) Weight: _____

Occupation: _____ Employer: _____

How did you hear about Renovare Health Therapy? _____

MEDICAL INFORMATION

FAMILY DOCTOR

Physician Name: _____ Date of Last Physical: _____

When did you last consult a doctor and for what reason? _____

_____

What is your regular exercise program? _____

Please list all current medications:

NAME OF MEDICATION	DOSAGE	REASON FOR USE

CHIROPRACTIC DOCTOR

Physician Name: _____

Date of Last Visit: _____ Reason for Care: _____

PRESENT CONDITION

Describe your CURRENT chief complaint: _____

_____

When did you first notice this issue? _____

Did something specific happen to trigger/cause these symptoms? _____

_____

Does anything in particular make it better or worse? _____

_____

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What have you done to care for this condition? _____

_____

What type of relief, if any, did it provide? _____

_____

KEY:

Circle "O" over areas of PAIN

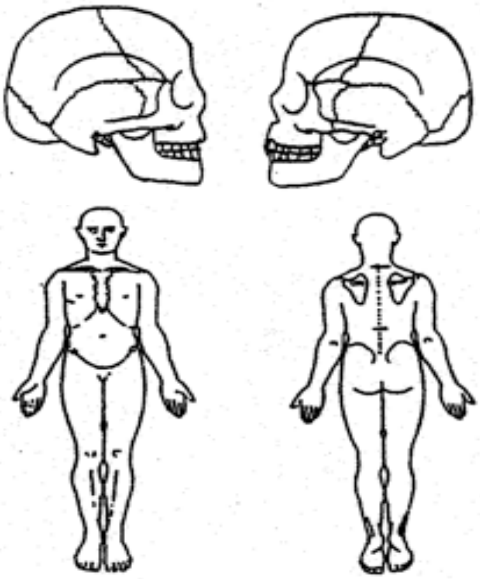
Write "X" over areas of JOINT & MUSCLE STIFFNESS

Draw "Squiggly Lines" over areas of NUMBNESS, TINGLING, or ALTERED SENSATION

Additional Comments:

_____

_____



FAMILY MEDICAL HISTORY

	Relationship		*Relationship*
Arthritis	_____	Diabetes	_____
Heart Disease	_____	Cancer	_____
Stroke	_____	OTHER	_____

PAST MEDICAL HISTORY

(Please include description and date)

Surgeries: _____

_____

_____

Accidents: _____

_____

_____

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OB/Gyn

Date of last period: _____

Are you currently pregnant? YES or NO
If yes, due date: _____

# of Pregnancies: _____
# of Caesarean Sections: _____

# of Births: _____
Hysterectomy? YES or NO

SYMPTOM CHECKLIST

Please mark the following symptoms that you have PRESENTLY or had PREVIOUSLY.

"O" = Occasional - "F" = Frequent - "C" = Constant

Musculoskeletal	**O**	**F**	**C**
Bone or Joint Disease	□	□	□
Tendonitis	□	□	□
Bursitis	□	□	□
Broken/Fractured bones	□	□	□
Arthritis	□	□	□
Sprains / Strains	□	□	□
Low Back, Hip, Leg pain	□	□	□
Neck, Shoulder, Arm pain	□	□	□
Headache / Head Injury	□	□	□
Spasms / Cramps	□	□	□
Jaw Pain / TMJ	□	□	□
Flat Feet / High Arches	□	□	□

Cardio-Respiratory	**O**	**F**	**C**
Asthma	□	□	□
Chest Pain	□	□	□
Chronic Cough	□	□	□
Difficulty Breathing	□	□	□
Pain in Left Arm	□	□	□
Spit up Blood	□	□	□
Spit up Phlegm	□	□	□
Tightness in Chest	□	□	□
Wheezing	□	□	□
Angina	□	□	□
Bronchitis	□	□	□
Hardening of the Arteries	□	□	□
High Blood Pressure	□	□	□
Low Blood Pressure	□	□	□
Poor Circulation	□	□	□
Rapid Heart Beat	□	□	□
Slow Heart Beat	□	□	□
Swelling of Ankles	□	□	□

Eyes	**O**	**F**	**C**
Blurred Vision	□	□	□
Corrective Lenses	□	□	□
Double Vision	□	□	□
Dryness	□	□	□
Itching	□	□	□
Pain	□	□	□
Sensitivity	□	□	□
Excessive Tearing	□	□	□

Ears	**O**	**F**	**C**
Discharges	□	□	□
Hearing Loss	□	□	□
Infections	□	□	□
Itching	□	□	□
Pain	□	□	□
Ringing	□	□	□

Skin	**O**	**F**	**C**
Dryness	□	□	□
Bruise Easily	□	□	□
Allergies	□	□	□
Rashes / Athletes Foot	□	□	□
Warts	□	□	□

Digestive	**O**	**F**	**C**
Constipation	□	□	□
Diarrhea	□	□	□
Gas/Bloating	□	□	□
Diverticulitis	□	□	□
Irritable Bowel Synd.	□	□	□
Gallbladder Disease	□	□	□
Hernias	□	□	□

Nervous System	**O**	**F**	**C**
Numbness / Tingling	□	□	□
Chronic Pain	□	□	□
Herpes / Shingles	□	□	□
Fatigue	□	□	□
Anxiety	□	□	□
Sleep Disorders	□	□	□

Genital-Urinary	**O**	**F**	**C**
PMS	□	□	□
Menopause	□	□	□
Frequent Urination	□	□	□
Kidney Infection	□	□	□
Painful Urination	□	□	□
Prostate Trouble	□	□	□

Other	**O**	**F**	**C**
Cancer / Tumors	□	□	□
Diabetes	□	□	□
Mental Health	□	□	□
Poor Nutrition	□	□	□
Drug Consumption	□	□	□
Alcohol Consumption	□	□	□
Nicotine Consumption	□	□	□
Caffeine Consumption	□	□	□
Other: _____	□	□	□
Other: _____	□	□	□
Other: _____	□	□	□
Other: _____	□	□	□
Other: _____	□	□	□

I have stated all my medical conditions that I am aware of and will update my practitioner of any changes in my health status.
I agree to the treatment approach recommended by my therapist.

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RELEASE AND CONSENT TO TREATMENT

I, _____ **understand** that the body therapy techniques, including, but not limited to Massage Therapy, Upledger CranioSacral Therapy®, Lymph Drainage Therapy®, and Somato Emotional Release®, is intended to enhance relaxation, increase communication within areas of the body, and to educate me to possible energetic or emotional blocks that may create pain and disease. I acknowledge that this type of bodywork is non-invasive, safe and objective. I acknowledge that this type of work is intended to utilize the body's own innate intelligence to establish communication within itself.

I understand this is not a substitute for medical treatment or medications. I am aware that the practitioner does not diagnose illness or disease nor does the practitioner prescribe medications.

I understand I may experience so called "detoxification symptoms" or releases during the next 24-72 hours following a treatment and that these symptoms may be somewhat uncomfortable depending on my physical, emotional and spiritual state of stability.

I understand that any types of therapies that may be described to me by the therapist are for my information only and are not intended to be considered as being prescribed or a referral by the practitioner.

I understand participation in a therapy session is voluntary and that at all times I may choose to end my participation. This type of therapy will include touch of specific areas of the body. The practitioner will inform me where the touching will occur, thus allowing for my ongoing consent.

I understand that if I have any condition that may be compromised by touch or pressure, I must inform the practitioner where and what they are so as to avoid any unnecessary aggravation. Should I have any questions or concerns, I will address them promptly with the practitioner.

I understand the particular therapeutic outcomes of these treatments, individually and jointly, cannot be predicted with certainty and no guarantee is made regarding any particular result or outcome.

I hereby authorize SHARON PIPPUS, RMT to provide me (or a minor if applicable) with body therapy sessions.

Signature: _____ Print Name: _____

Date: _____

Witness: _____ Print Name: _____