Sephira Healing Health Information

Contact Information

Name: _____ Occupation: _____

Address: _____ Postal Code: _____

Email: _____ Birthdate: _____

Home phone: _____ Work _____ Cell: _____

Doctor _____ Phone: _____

Referred by: _____

Initial Visit

Current concern?

_____

Other concerns?

_____

When did it begin and how?

_____

What activities aggravate it?

_____

What relieves it?

_____

What is your goal for these treatments?

_____

Are you currently taking any medications? (circle for 'Yes')

pain killers muscle relaxants antiinflammatories aspirin/tylenol sleeping pills antidepressants other

Are you/have been treated by other practitioners? (circle for 'Yes')

Registered Massage Therapist Chiropractor Physiotherapist

Have you ever had a major accident, illness, surgery or injury?_____

Did the current injury result from a major accident, illness, surgery or injury?_____

Have you had any of the following regarding your current condition: (circle for 'Yes')

doctor's exam xray diagnostic tests

What is your stress level? (circle for 'Yes'): **severe** **moderate** **slight** **none**

Are you satisfied with your (circle for 'Yes'):

overall health ability to relax fitness energy level diet sleep

What is your intake of:

alcohol_____ coffee_____ tobacco_____ water_____ sugar_____

Please fill out the back of the next page.

Do you have any difficulty with the following (please check):

General
- ☐ insomnia
- ☐ diabetes
- ☐ fatigue
- ☐ irritability
- ☐ inner tension
- ☐ cold sweats
- ☐ rheumatic fever
- ☐ post-polio
- ☐ cancer
- ☐ HIV/AIDS

Movement
- ☐ strain/sprain/spasm
- ☐ joint problems
- ☐ tendonitis
- ☐ bursitis
- ☐ arthritis
- ☐ dislocation
- ☐ bone fracture
- ☐ osteoporosis
- ☐ frozen shoulder
- ☐ poor posture

Upper Body
- ☐ muscle tension
- ☐ headaches
- ☐ migraines
- ☐ whiplash
- ☐ head injury
- ☐ jaw/dental pain
- ☐ ringing ears
- ☐ disc problems
- ☐ spine injury

Nervous System
- ☐ anxiety
- ☐ depression
- ☐ dizzyness/fainting
- ☐ numbness/tingling
- ☐ paralysis
- ☐ memory loss
- ☐ sciatica
- ☐ epilepsy
- ☐ loss of taste/smell
- ☐ emotional stress

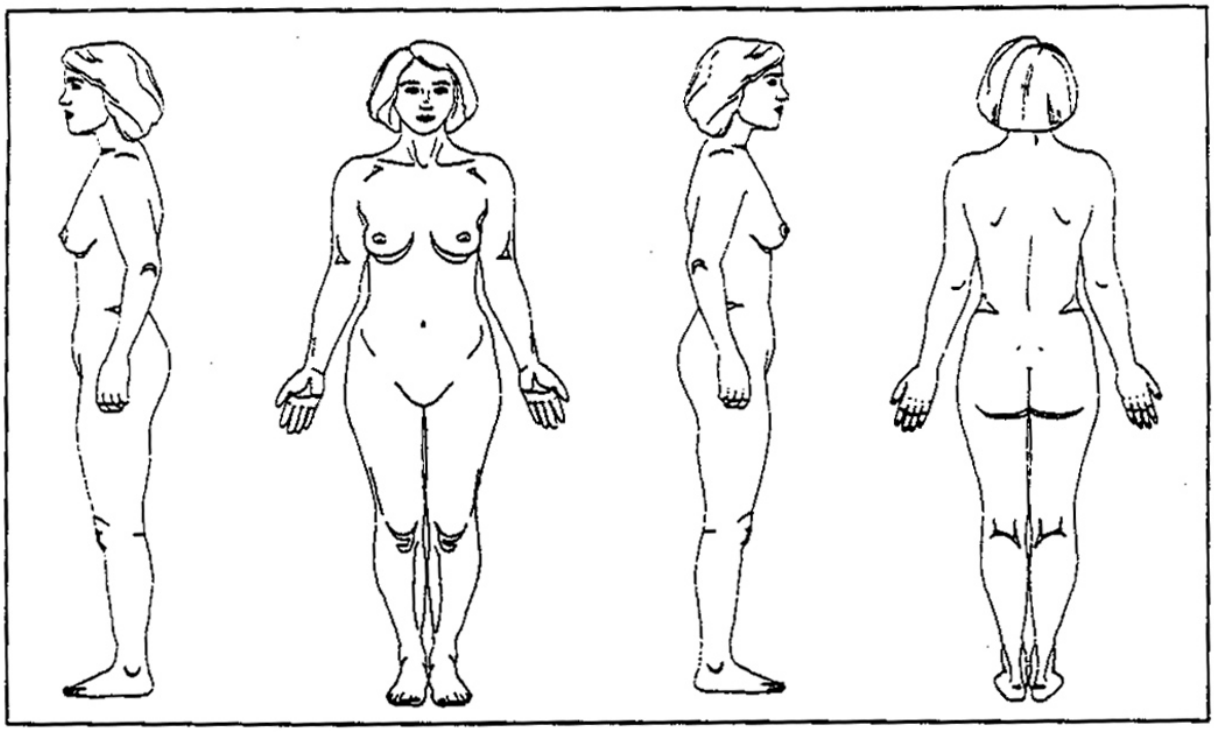
Women
- ☐ painful period
- ☐ irregular period
- ☐ PMS
- ☐ endometriosis
- ☐ menopause
- ☐ pregnancy
- ☐ breast pain
- ☐ breast conditions
- ☐ breast surgery
- ☐ trauma

Respiratory
- ☐ difficult breathing
- ☐ asthma
- ☐ pneumonia
- ☐ chromic bronchitis
- ☐ hay fever
- ☐ sinus trouble
- ☐ emphysema
- ☐ tuberculosis

Cardiovascular
- ☐ shortness of breath
- ☐ chest pain
- ☐ heart palpitation
- ☐ high/low blood pressure
- ☐ heart attack
- ☐ stroke
- ☐ poor circulation
- ☐ varicose veins
- ☐ anemia

Abdominal
- ☐ abdominal pain
- ☐ indigestion
- ☐ ulcers
- ☐ hernia
- ☐ constipation
- ☐ diarrhea
- ☐ kidney disease
- ☐ bladder
- ☐ infection

Diagram for therapist's postural assessment



Informed Consent and Release:

I hereby consent to have Pam Fichtner, RMT, treat me with a variety of techniques including, but not limited to: massage therapy, breast massage, lymphatic drainage, craniosacral therapy, somatoemotional release, visceral manipulation and energy balancing.
I agree that Pam must be fully aware of my existing medical conditions and it is my responsibility to keep her updated on my medical history.
I understand that all information given is confidential and authorize Pam to release or obtain information pertaining to my condition & treatment from other health care professionals or caregivers.
I understand that at any time I may withdraw consent and the treatment can be stopped or modified accordingly.
Fees are $110 for 90 minutes, $75 for one hour, $60 for 45 minutes, and $40 for a half hour, plus GST.
I agree to advise Pam of a cancellation within 24 hours in advance or I will be charged the full fee.

Date:_____ **Signature:**_____

Update _____ Update _____ Update _____ Update _____ Update _____ Update _____

Update _____ Update _____ Update _____ Update _____ Update _____ Update _____