HOLISTIC WELLNESS OTTAWA

Clinical Somatic Therapy Intake

Name: _____ **Birth Date:** _____

Occupation?: _____

Referred by? _____

Any specific concerns? Please explain: _____

_____

How many times per week are you physically active? _____ **What activities do you do?:** _____

_____

Current medications and conditions being treated: _____

_____

Surgeries / injuries and areas of concern, dates: _____

_____

Have you ever had any of the following?

Cardiovascular

Blood pressure: High _____ Low _____ Congestive heart failure _____ Heart attack _____

Phlebitis _____ Stoke / CVA _____ Pacemaker _____

Other? _____

Respiratory

Chronic cough _____ Shortness of breath _____ Bronchitis _____ Asthma _____ Emphysema _____

Other? _____

Head / Neck

Vision problems ____ Vision loss ____ Ear problems ____ Hearing loss ____ Dizziness ____ Headaches ____ Migraines ____

Other? _____

Infections

Hepatitis _____ Skin conditions _____ TB _____ HIV _____ Malaria _____

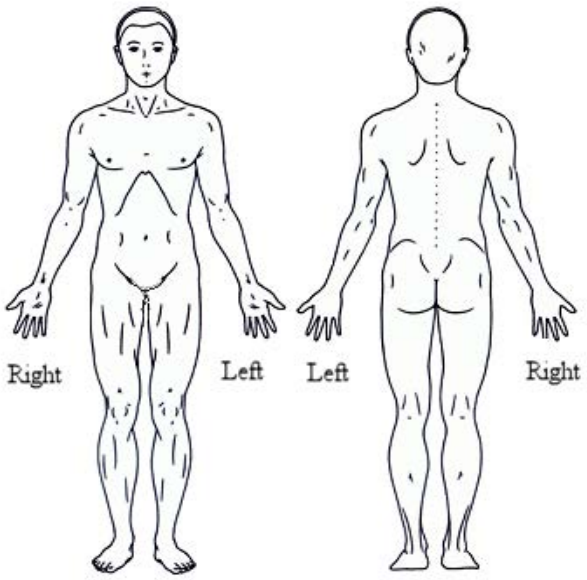
Other? _____

Other Conditions

Skin irritations _____ Epilepsy _____ Cancer _____ Rods/pins/joint surgery _____ Allergies _____ Diabetes. Onset: _____

Women: Pregnant? Due date? _____ Gynaecological concerns _____

Using symbols below, mark on body diagram:



O = Pain.
Type: Dull / ache / sharp / dull

X = Stiffness
Type: muscle / skin / joint

On a scale of 1 (mild) – 10 (extreme),
how would you rate your pain level today? _____

Informed Consent to Treatment

I understand that Clinical Somatic Therapy is a hands-on modality. It combines different techniques based on the principles of Somatic Education, including advice on posture and exercises.
I understand that in order to gain the greatest benefit I will need to be an active participant in the Therapy sessions. I also understand that the goal of this therapy is, in part, to provide me with the necessary tools, including any exercises and movements that are indicated, as a way to practice on my own and continue my healing. I acknowledge that failing to utilize these tools as recommended may limit the success of any course of treatments.
I understand that the treatment and advice provided by the practitioner is not in place of, or to the exclusion of, any other treatment or advice that I am now be receiving, or may in the future receive, from a physician, surgeon, or any other licensed health practitioner.
I understand that I am to continue all medications and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them.
It is my responsibility to inform my practitioner of any pre-existing medical conditions, injuries or disease, and to inform the practitioner of any changes in my condition during the course of treatment.
I understand that at times my practitioner may request that I remove outer clothing in order to facilitate the most effective treatment and that it is my choice as to whether I do this. It is my responsibility to inform my practitioner if I am not comfortable removing this clothing.
I understand that is my responsibility to inform my practitioner immediately if, at any time, I am not comfortable with what they are doing.
I understand that my practitioner reserves the right to discontinue services where it is apparent that my expectations and the type of services provided are not compatible.
I understand that a confidential record will be kept of the health services provided to me and that I may view my records at any time.
I understand that results are not guaranteed. I do not expect my practitioner to be able to anticipate and explain all risks and complications. With this knowledge I voluntarily consent to Clinical Somatic Therapy.
I intend this consent to cover the entire course of treatment. I understand that I am free to withdraw my consent at any time.

Patient Name _____ Guardian Name: _____

Patient / Guardian Signature_____ Date: _____

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