CONFIDENTIAL CLIENT HISTORY FORM

An accurate health history is important to ensure that it is safe for you to receive an ABM treatment. If your health status changes, please let us know. All information gathered is confidential except as required or allowed by law.

PERSONAL DATA

Name:_____ **Email:**_____ **Date:**____/____/_____

Address:_____ **City:**_____ **Prov:**____ **Postal Code:**_____

Home Phone#:_____ **Work#:**_____ **Cell#:**_____

Birth Date (MM/DD/YYYY):_____/_____/_____ **Age:**_____

Occupation:_____ **Family Physician:**_____

How did you hear about us?:_____ **Hobbies:**_____

Emergency Contact:_____ **Tel#:**_____

Payment Method: Cash | Etransfer | Cheque | Credit Card

HEALTH HISTORY

1. **Have you had previous ABM treatments? Yes____ No ____**

   If yes, name of attending practitioner _____**Date of last treatment** _____

2. **Are you presently receiving other treatment/manual therapy (Physio, Chiro, etc.)? Yes____ No ____**

   If yes, please specify _____**Name of practitioner** _____

3. **Are you presently utilizing any type of physical aid or appliance? ie: prosthesis, mouth guard, orthotics, etc.**

   If yes, please specify_____

4. **What is your primary reason for having an ABM Treatment?**

   Please Specify: _____

5. **Do you have pain, stiffness or other symptoms in any of the following areas?**
   Please indicate from 1-10 with 10 being the worst:

Neck	_____	**Chest**	_____ **R/ L/ Centre**
Jaw	_____	**Ribs**	_____ **R / L**
Headaches	_____ **Location**_____	**Hips**	_____ **R / L**
Upper back	_____ **R/ L/ Centre**	**Legs**	_____ **R / L**
Middle back	_____ **R/ L/ Centre**	**Knees**	_____ **R / L**
Lower back	_____ **R/ L/ Centre**	**Ankles**	_____ **R/ L/ both**
Tail bone	_____	**Feet**	_____ **R/ L/ both**
Shoulders	_____ **R/ L/ both**	**Throat**	_____
Arms	_____ **R/ L/ both**	**Abdomen**	_____
Elbows	_____ **R/ L/ both**	**Heart** (circle)**: Pacemaker / Attacks**	
Hand	_____ **R/ L/ both**	**Date(s):**_____	
Wrist	_____ **R/ L/ both**	**Digestive Issues:** _____	

Extra Notes:_____

_____

_____

_____

_____

_____

_____

6. **Do you have trouble lying on your (circle): back // side // front // standing // walking // stair climbing**

7. **What other limitations do you currently have? ie: reaching, bending, shoulder checking, balance, coordination etc.**
   List them here:_____
   _____

8. **How well are you eating?** _____
   _____

9. **How good are your Bowel Movements? (Regularity / Any concerns?)** _____
   _____

10. **Do you have any health concerns other than your present symptoms? Yes____ No ____**
    If yes, please explain: _____
    _____

11. **Are you presently pregnant? Yes _____ (# of weeks _____) Due date: _____**
    Do you have any pregnancy related concerns or issues? _____

12. **Are you taking any medications? Yes___ No ___ If yes, please specify reason for taking (ie: cholesterol, anxiety, etc.):**
    _____

13. **Surgical Procedures:**

	Approximate Date		Approximate Date
Spinal surgery	_____	**Appendix**	_____
Knees	_____	**Kidney Stones**	_____
Hips	_____	**Hysterectomy**	_____
Plates/Pins	_____	**C-Section**	_____
Gall Bladder	_____	**Other**	_____

Extra Notes:_____
_____
_____
_____
_____
_____

14. **Have you ever been hospitalized for any other reason? Yes____ No ____**
    If yes, please explain _____

15. **Have you had any significant accidents or injuries? ie: motor vehicle, falls, concussions? Yes____ No ____**
    If yes, please specify _____
    _____

16. **Have you been treated for any psychological concerns? ie: Depression Yes____ No ____**
    Do you or have you experienced anxiousness and/or panic attacks? Yes____ No ____

17. **Any Alcohol or Drug related problems?** _____
    _____

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18. Approximate Date of last:
Complete physical exam: _____ Blood pressure check: _____ Heart exam: _____

X-ray: _____ MRI: _____ EMG: _____ CT Scan: _____

Extra Notes:_____

_____

_____

19. Things you want to get back doing again that you've stopped doing?_____

_____

_____

_____

20. Any other questions or concerns? _____

_____

_____

_____

INFORMED CONSENT TO ABM NeuroMovement TREATMENT

I understand that the ABM Practitioner is providing ABM NeuroMovement Lessons within their scope of practice.

I hereby consent for my Practitioner to treat me with ABM for the above noted purposes including such assessments, examinations and techniques.

I acknowledge that the Practitioner is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that ABM is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the Practitioner must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Practitioner and disclosed to the Practitioner all of those medical conditions affecting me. It is my responsibility to keep the Practitioner updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my Practitioner to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my lesson. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my Practitioner from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

MOVE Therapies reserves the right to charge the full applicable treatment fee for missed or cancelled appointments if 24 hours notice has not been received. Subject to change without notice. For more details please review the policies on our website.

***** Client Signature: _____Date:_____**

Client's Parent/Legal Guardian (if under 18 years old): _____

Parents and/or legal guardians of clients under 16 years of age are required to be present in the treatment room during all treatments and or consultations. NO EXCEPTIONS! Clients between 16 and 18 years of age require written consent prior to commencing treatment and or consultations.