# 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:**_____

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

**Payment Method (circle): Cash | Etransfer | Cheque | Credit Card**

## HEALTH HISTORY

1. **What is your primary reason for having an MOVE Therapies Treatment?**

   **Please Specify:** _____

   _____

   _____

2. **Are you presently receiving other treatment/manual therapy (Physio, Chiro, etc.)? Yes____ No ____**
   **If yes, please specify** _____**Name of practitioner** _____
3. **Do you have trouble lying on your (circle): back // side // front // standing // walking // stair climbing**
4. **What other limitations do you currently have? ie: reaching, bending, shoulder checking, balance, coordination etc.**

   **List them here:**_____

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

   **If yes, please specify**_____
6. **How well are you eating (any digestive issues)?**

   _____

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

   _____
8. **Do you have any health concerns other than your present symptoms? Yes____ No ____**

   **If yes, please explain:** _____

   _____
9. **Are you presently pregnant? Yes _____ (# of weeks _____) Due date: _____**

   **Do you have any pregnancy related concerns or issues?** _____
10. **Are you taking any medications? Yes___ No ___ If yes, please specify reason for taking (ie: cholesterol, anxiety, etc.):**

    _____

    _____

**11. Surgical Procedures:**

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

**Extra Notes:**_____

_____

_____

_____

**12. Have you ever been hospitalized for any other reason? Yes____ No ____**

**If yes, please explain** _____

_____

**13. Have you had any significant accidents or injuries? ie: motor vehicle, falls, concussions? Yes____ No ____**

**If yes, please specify** _____

_____

_____

**14. 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 ____**

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

_____

**16. Medical Exams**

| | Approximate Date | | Approximate Date |
|---|---|---|---|
| **Complete Physical exam:** | _____ | **X-ray:** | _____ |
| **Blood pressure check:** | _____ | **MRI:** | _____ |
| **Heart exam:** | _____ | **EEG:** | _____ |
| **CT Scan:** | _____ | | |

**Extra Notes:**_____

_____

_____

**17. How did you hear about us?:**_____

**18. Hobbies:**_____

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

_____

_____

_____

_____

**20. Any other questions or concerns?** _____

_____

_____

_____

_____

**I**

**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.**