MuscleElements
Health & Wellness

#3, 9 Chippewa Road, Sherwood Park, AB, T8A 6J7
Phone: 780.410.1100 Fax: 780.410.1186

Liliana Hernandez-Prada
Registered Manual Osteopath
Member of the National Manual Osteopathic Society

Name: ____ Gender: Male Female

Date of Birth:_________________(DD-MM-YY) Occupation: ______________________

Address: ____

Insurance Company: ______________ Policy No: _____________Insured ID: _________

Group No. ________________________ Cell: ______________________________

E-mail Address: ____

Emergency Contact: ____

Please initial if your emergency contact or another contact can schedule and/or cancel appointments on your behalf: ____________

How did you hear about the Manual Osteopathy service in our Clinic? Please circle

Walk-in Google Website Friend Brochure Other: __________

Name of Medical Doctor: _________________________ Tel: _____________________

Date of last appointment: ________________ Date of last physical: _______________

Are you receiving treatment from other health care professional? YES NO

If YES, please explain: ____

The health information requested on the following form will assist us in treating you safely. If you have any questions about the requested information please feel free to ask. Your written permission is required to release any information, unless required by law.

Primary reason for first visit: ____

When did this begin? ____

How did this occur? ____

Since it began has the condition: ☐ Improved ☐ Worsened ☐ Unchanged

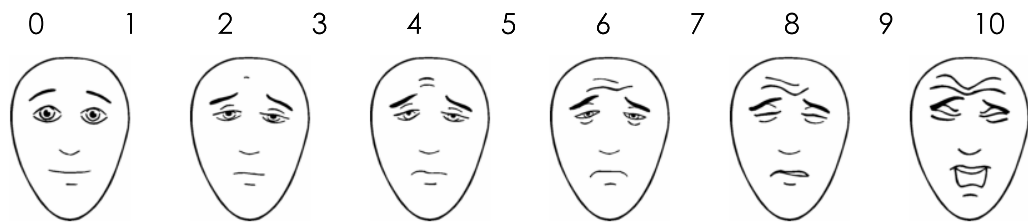
What have you done for this condition? _______________________________________

Describe your general health: ______________________________________

Using symbols, mark on body diagram:

O: pain
Z: Tingling
/: Other

Using the line scale, indicate the severity of the pain you are experiencing now by circling a number:



Special Considerations (circle those that apply):
Pacemaker   Rods/Pins/Wires   Artificial Joints   Medication Patch

Other: ____

Circle and explain (dates, procedures, etc.) In area below:

Yes☐ No ☐ Have you ever been in a car accident?

Yes☐ No ☐ Have you ever experienced a hard fall onto your back or buttocks?

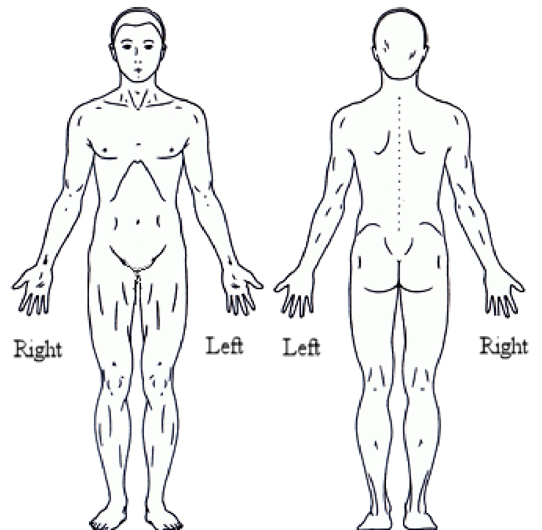
Yes☐ No ☐ Have you ever experienced a hard blow to your head or a concussion?

Yes☐ No ☐ Have you ever had a surgical procedure?

Yes☐ No ☐ Do you have any children?

No. of children ________________ No. of C-Sections ________________

Are you pregnant now? ☐ Yes ☐ No



Current Medications: ________________________

Reason for taking the medication: ________________________

________________________ ________________________

________________________ ________________________

Do you at the **present time** experience:

☐ Yes ☐ No Dizziness, weakness, fainting, vertigo, drop attacks or disorientation?

☐ Yes ☐ No Disturbances of vision, speech co-ordination or balance, or difficulty swallowing?

☐ Yes ☐ No Numbness or pins and needles in any part of your body?

Where? ________________________

☐ Yes ☐ No Difficulty with bowel or bladder function?

☐ Yes ☐ No Cough, shortness of breath, chest pain, or palpitations?

☐ Yes ☐ No Poor appetite, nausea or vomiting?

☐ Yes ☐ No Difficulty Sleeping?

☐ Yes ☐ No A significant weight change in the past year?

Have you **ever** experienced?

☐ Yes ☐ No Recurrent ear, throat or sinus infection?

☐ Yes ☐ No Respiratory disease or disorders? (i.e. asthma, pneumonia etc.)

☐ Yes ☐ No Stomach, intestinal or any digestive problems?

☐ Yes ☐ No Bladder or kidney problems? (i.e. infection, kidney stones, etc.)

☐ Yes ☐ No Gynecological conditions? (i.e. endometriosis, cysts, fibroids, etc)

☐ Yes ☐ No Have you ever consulted a physician for any of the above?

If yes, please explain: ________________________

____

Do you have any of the following conditions?

☐ Diabetes
☐ Cancer
☐ Allergies

____

☐ Heart Disease/ Problem
☐ High/Low blood pressure
☐ Stroke/CVA
☐ Epilepsy (type)

____

☐ Asthma
☐ Migraines
☐ Headaches (type)

____

☐ Hepatitis
☐ HIV/AIDS
☐ STD
☐ Tuberculosis
☐ Arthritis (type)

____

☐ Skin Conditions
☐ Other

____

Family History: Please identify any problems listed above that have occurred in your immediate family (indicate family members affected)

Ailment	Affected
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Client Consent to Assessment /Treatment

Treatments may include manual therapies where the health practitioner places her hands on your body. Many techniques will involve contact between your body and the practitioner's body. Body and hand contact may include areas of your chest wall, abdomen, pelvic floor and pubic bones. If intraoral work is required, disposable latex or vinyl gloves will be worn.

At times, the practitioner may ask you to remove some items of clothing in order to facilitate treatment. If you do not feel comfortable with any part of the treatment, please tell us immediately. The technique can be discontinued or modified to be comfortable for you.

Fees and Payment

Manual Osteopathy

Initial Assessment + first treatment (60min)…..$ 140.00

Follow up (60min)…………………………………$ 120.00

Payments for services are the responsibility of the patient and are to be paid at each visit. If a third party payer denies your claim and /or refuses to pay for the full amount billed, you are responsible for paying the outstanding amount.

Cash and Debit are our preferred methods of payment, however VISA and MasterCard, are accepted. We do not accept personal cheques.

I understand the fees and payment schedule policy ______Initials

Cancellation and no show policy

Out of respect for your therapist and your fellow patients, we appreciate 24 hour advance notice of cancellation. I you cancel your appointment with less than 24 hours notice you will be charged the full visit fee. If you do not attend a scheduled appointment and do not call to cancel or reschedule (no show), you will be charged the full visit charge.

I understand the cancellation and no show policy. _______Initials

I have read, understood and am in agreement with all of the above information.

____ ________________________________

Signed Date

(guardian must sign if patient is a minor)

Fertility Massage (Mercier Therapy)
Informed Consent and Release Form

I understand that Fertility Massage is a soft tissue visceral manipulation therapy technique used to help and restore the health and general well being of the female pelvis.

I understand the goal of pelvic treatment is to decrease adhesions in and around organs, ligaments, muscles, joints and support structures of the pelvis, abdomen, hips and low back.

I understand that if I experience any pain or discomfort during a session, I will immediately inform the practitioner so that the pressure and/or application may be adjusted to my level of comfort.

I understand that Fertility Massage should not be construed as a substitute for a medical examination, diagnosis or prescription.

I should see a Gynecologist, Reproductive Endocrinologist or other qualified medical specialist for any physical ailment or suspect condition I might have.

I understand that Fertility Massage is not intended to take the place of medical/surgical intervention and neither practitioner nor Muscle Elements Health and Wellness shall not bear any responsibility for any ill effects should I choose to NOT adhere to my primary doctor's advice.

I understand that the practitioner is not qualified to diagnose, prescribe or treat any emotional or mental distress and nothing said in the course of the session (s) given should be construed as such. Because Fertility Massage is contraindicated (should not be done) under certain medical conditions (IUD, Essure, Endometriosis during menses, any present cancer cells) I affirm that I have stated all my known medical conditions and answered all questions honestly.

I agree to keep the practitioner updated as to any changes in my medical profile and understand that there will be no liability on the practitioner or Muscle Elements Health and Wellness should I forget. Supplements recommended or suggested to me are taken/ingested by my choice/decision.

I will not hold the practitioner or Muscle Elements Health and Wellness responsible nor liable should I have an adverse or allergic reaction.

I understand the remainder of treatment sessions will resume post partum should I conceive during the program.

I will honor all office policies including but not limited to payment, cancellation notice, tardiness and conduct.

I understand refunds are not given for any reason.

I understand compliance is necessary for successful treatment progress and results.

I understand there is no guarantee of pelvic cure or pregnancy.

I have read, fully understand, and agree to the above terms and conditions.
Print

Name:_______________________________________Signature:_______________________________________

Date:______________________

Privacy Policy

The information received and collected about our clients/patients from their visit to Muscle Elements is strictly private and confidential. It is used and viewed only by the healthcare professionals and staff employed by Muscle Elements, unless, in the best interest of the client/patient, a practitioner determines that there is a need to communicate with another person or healthcare professional outside of Muscle Elements (also, Muscle Elements will not give, share, sell or transfer any personal information to a third party unless required by law). Under absolutely no circumstances would this communication happen without the signed consent of the client/patient. The client/patient information will be stored both in digital and hard copy format on Muscle Elements premises.

Name: _____________________________________ Signature: ____________________________________

Date: ____________________________