SACRED GROUND HEALTH
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CONFIDENTIAL PATIENT HISTORY FORM

Today's Date: _____

Last Name_____ First Name _____

Birthdate (M/D/YR) _____ Sex: M( ) F( ) O( ) Marital Status: S( ) M( ) W( ) D( )

Address_____ Phone (Home)_____

_____ Phone (Cell)_____

Email_____ Phone (Work) _____

Would you like to be added to the mailing list? ( ) YES ( ) NO

Occupation_____

Medical Doctor _____ Phone _____

Referred By _____ Phone _____

Emergency Contact _____ Phone _____

MEDICAL HISTORY

Current concerns/reason for visit *(use diagram to indicate as needed)*: _____

_____

_____

_____

Please also list/draw in past injuries,

accidents, surgery (with approx month/yr):

_____

_____

_____

_____

_____

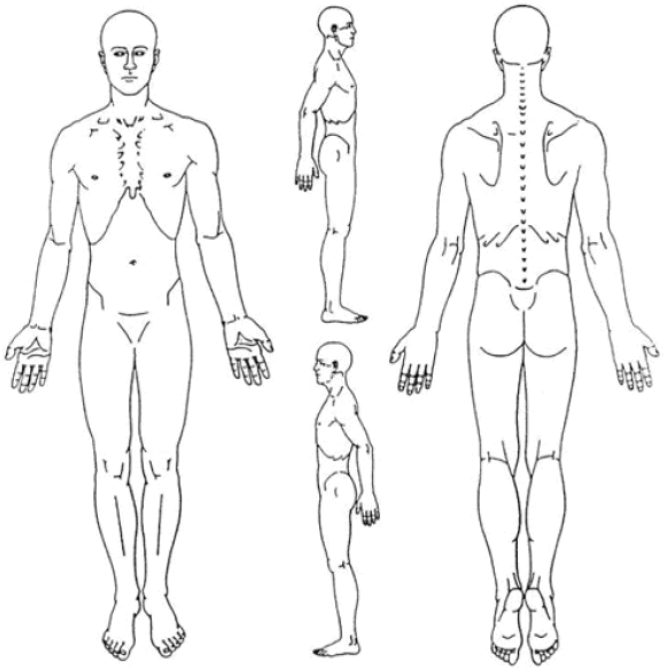
_____

_____

_____

_____

_____



Are you presently taking any medications, vitamins, minerals or other supplements? YES___ NO___

If YES, what type and for what condition(s)? _____

_____

_____

Do you have any known allergies (medications, foods, oils and lotions, etc.)?

_____

_____

Do you have any pins, wires, implants, artificial joint, IUD, pacemaker, metal screws, plates, etc.?

please CIRCLE or list other(s) here: _____

LIFESTYLE:

	Heavy	*Moderate*	*Light*	*None*
Sugar	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Coffee/Tea	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Exercise	_____	_____	_____	_____

Hours of sleep per night (approx.) _____

Number of meals you regularly eat per day _____

Number of times you engage in physical activity per week _____

Please CIRCLE the answer closest to how you presently feel: (1 = poor, 5 = excellent)

Energy Level	1 2 3 4 5
Eating Habits	1 2 3 4 5
Dealing With Stress	1 2 3 4 5
Physical Activity Habits	1 2 3 4 5
Quality of Sleep	1 2 3 4 5

OTHER THERAPY/TREATMENT: *(please CIRCLE; past or present, does not have to be related to this visit)*

Massage Therapy Chiropractic Physiotherapy Naturopath Acupuncture Other:_____

INFORMED CONSENT:

I have requested physical assessment and treatment by Rahim Valli, RMT [therapist] and recognize in this his implied responsibility as a certified healthcare practitioner. I understand that treatment may include any of the following therapies: *CranioSacral Therapy; Trigger Point Therapy; Fascial Release; Muscle Energy Technique; Massage Therapy; Joint Mobilization*

I understand that results are not guaranteed. I do not hold Rahim Valli nor Sacred Ground Health responsible for complications that may occur as a result of the treatments rendered. Should treatment result in *SomatoEmotional Release*, therapist assumes no responsibility for the content.

I understand that it is my responsibility to give 24hrs notice should I need to cancel my appointment; I will be charged in full for no-show appointments or appointments cancelled on the same day. I have read the above consent, asked any questions I had and consent to receive treatment. I mean for this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Signature _____ Date _____

Signature of Parent/Guardian_____ Date _____
(as applicable)

- Have you had any difficulties with the following in the past? If yes, please mark "P" for PAST.
- Do you *currently* have any difficulties with the following? If yes, please mark "C" for CURRENT.

_____ Fever
_____ Nausea
_____ Chills
_____ Sweats
_____ Fainting
_____ Dizziness
_____ Convulsions
_____ Difficulty sleeping
_____ Fatigue
_____ Nervousness
_____ Poor Appetite
_____ Asthma
_____ Gum trouble
_____ Frequent colds
_____ Enlarged thyroid
_____ Tonsillitis
_____ Sinus infection
_____ Nasal drainage
_____ Enlarged glands
_____ Skin eruptions
_____ communicable skin infections
_____ Itching
_____ eczema
_____ rashes
_____ Dryness of skin
_____ Bruise easily
_____ Shortness of breath
_____ Previous heart stroke
_____ Hardening of arteries
_____ Swelling of ankles
_____ Poor circulation
_____ Paralytic stroke
_____ Stiff neck
_____ Back ache
_____ Neck pain
_____ Swollen joints
_____ Painful tailbone
_____ Other _____

_____ Inability to control _____

_____ Foot problems
_____ Loss of weight
_____ Numbness or pain in arms, hands, legs
_____ Excessive thirst
_____ Vision problems
_____ Eye pain
_____ Deafness
_____ Earache
_____ Ear discharge
_____ Nasal Obstruction
_____ Frequent nose bleeds
_____ Sore throat
_____ Hoarseness
_____ Hay fever
_____ Wheezing
_____ Difficult digestion
_____ Vomiting
_____ Constipation
_____ Parasites
_____ Jaundice

_____ Boils
_____ Hives or allergies

_____ Varicose veins
_____ Sensitive skin
_____ Chronic cough
_____ Spitting up phlegm
_____ Spitting up blood
_____ Chest pain
_____ Difficulty breathing
_____ Rapid heartbeat
_____ Slow heartbeat
_____ High blood pressure
_____ Low blood pressure
_____ Pain over heart
_____ Excessive hunger
_____ Vomiting blood

_____ Colon trouble
_____ Liver trouble

_____ Shoulder pain
_____ Faulty posture
_____ Arthritis
_____ Muscle weakness
_____ Fracture(s) _____

_____ Frequent urination
_____ Painful urination
_____ Blood in urine
_____ Pus in urine
_____ Kidney infection
_____ Kidney stone
_____ Bed wetting
_____ Inability to control urine
_____ Belching / Gas
_____ Pain over stomach
_____ Hemorrhoids (Piles)
_____ Colitis

Women

_____ Pregnant or think you might be?
_____ Painful menstruation
_____ Irregular cycle
_____ Vaginal discharge
_____ Menopausal symptoms
_____ Excessive flow
_____ Cramps or backache
_____ # of pregnancies
_____ # of children
_____ Congested breast
_____ Lumps in breast
_____ Hot flashes
_____ Miscarriage
_____ Other _____

Men

_____ Prostate trouble
_____ Painful urination
_____ Urinary infections
_____ Other _____

Is there anything else you feel would be helpful for me to know about you?

_____

_____

_____