Holistic Oasis Studio Inc.
#120 Riverstone Crescent SE
403-720-0860

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the utmost treatment, we need you to complete this questionnaire. All information will be kept strictly confidential.

PERSONAL HISTORY:

Client Name: _____

Date of Birth: _____ Age:____ Sex: Male ❒ Female ❒

Marital Status: ❒ Married ❒ Single ❒ Divorced ❒ Separated

Address:_____ City_____

Province:_____ Postal Code_____

Phone: Home: _____ Work: _____ Cell:_____

Email: _____

Current Medical Problems: (check all that are applicable)

❒ Chest Pain	❒ Weight loss/Gain	❒ Thirst	❒ Blood Disorder
❒ Shortness of breath	❒ Nausea/Vomiting	❒ Thyroid Problems/Goitre	❒ Anaemia/Iron
❒Dizziness/Fainting	❒ Vomit Blood	❒ Diabetes	❒ Muscle Pain ❒ Join/Bone Pain
❒ Palpitations/Rapid heart action	❒ Difficulty Swallowing	❒ Swollen Glands	
❒ Pacemaker	❒Hiatus Hernia/Ulcer	❒ Always cold/warm	❒ Smoker (ever)
❒ Ankle swelling	❒ Abdominal Pain/cramps	❒ Pain	❒ Alcohol/drug use
❒ Heart murmur	❒ Bowel Problems	❒ Headache	❒ Depression
❒ High Blood Pressure	❒ Diarrhea	❒ Visual Problems	❒ Anxiety
❒ Cholesterol	❒ Constipation	❒ Stroke	❒ Seasonal Allergies
❒ Leg cramps/Poor circulation	❒ Blood in stool	❒ Seizure	❒ Ear/Sinus Problems
❒ Heartburn/ Indigestion	❒ Hepatitis	❒ Weakness/ Numbness	❒ Cancer
❒ Gas	❒Itch	❒ Mouth Sores	❒Nutrition Problem
❒ Asthma/Wheezing	❒ Difficulty Urinating	❒ Hives	
❒ Snoring	❒ Kidney stones	❒ Skin/Hair problems	
❒ Stop breathing at night	❒ Sexual Problems	❒ Bruising/bleeding	
❒ Sleepiness/ Insomnia	❒ Menstrual/Breast Problems	❒ Blood Clots/Phlebitis	

HISTORY:

Are you pregnant? Yes ❒ No ❒

Have you had a vasectomy? Yes ❒ No ❒

Have you had breast implants? Yes ❒ No ❒

Have you had hip surgery? Yes ❒ No ❒

Have you had jaw surgery? Yes ❒ No ❒

Where would you rate your stress level?
Overwhelming ❒ High ❒ Moderate ❒ Low ❒

Do you see a doctor regularly? Yes ❒ No ❒

Have you ever had previous treatments in Holistic therapies? Yes ❒ No ❒
If yes which ones? _____

Do you exercise regularly? Yes ❒ No ❒

Medical Injuries/Illnesses	Date	Surgeries	Date

List Medications You Take:	Drug Allergies:

What are your main health concerns that you would like addressed:
1._____
2._____
3._____
4._____
5._____

Is there anything important that we haven't covered?
_____
_____
_____
_____
_____

<u>Please Note</u>:

There will be a $25.00 fee charged for a missed appointment or less than 24 hours notice for cancelling an appointment.

Thank You!

Signature: _____ Date: _____