Therapy One
NATURAL HEALTH CENTRE

Patient Health History Form

First & Last Name: _____ **DOB (DD/MM/YY):**____/____/____ □ **M** □ **F**

Address: _____ **City/Province:** _____**Postal Code:** _____

Occupation: _____ *** Email (Please Print)** _____

Tel #: (_____) _____**Work:** (_____) _____ **Cell:** (_____) _____

Emergency Contact Name: _____ **Tel #** (_____) _____

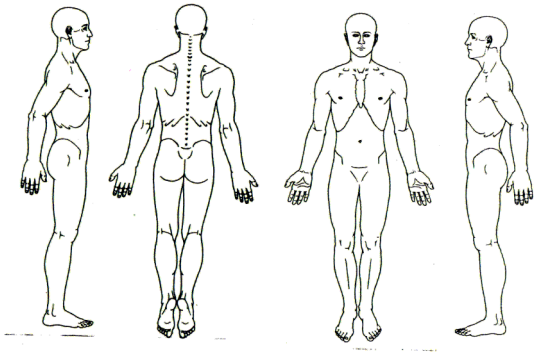
Family Physician Name :_____ **Tel #** (_____) _____

Family Physician Address: _____

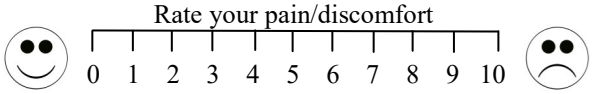
What is your current complaint? _____ **For How long ?** _____

Currently receiving treatments from any health care practioner ? ☐ No ☐ Yes, _____

Indicate in the pictures below the location(s) of your complaint



Rate your pain/discomfort



Was the onset ☐ Sudden ☐ Following a trauma
☐ Gradual ☐ No specific reason noted

How often is the discomfort present?
☐ Intermittent (25% or less) ☐ Occasional (25%-50%)
☐ Frequent (50%-75%) ☐ Constant (75%-100%)

What makes your condition **BETTER?**
☐ Lying down ☐ Sitting ☐ Standing ☐ Walking
☐ Exercise ☐ Rest ☐ Nothing

What makes your condition **WORSE?**
☐ Lying down ☐ Sitting ☐ Standing ☐ Walking
☐ Exercise ☐ Rest ☐ Nothing

☐ I have no problems and feel well. I'm interested in strategies and care to help optimize my health

Is your primary concern related to a motor vehicle accident ?
☐ Yes ☐ No , If YES Date: (DD/MM/YYYY):____/____/_____

List any previous injuries/surgeries/serious illnesses

Injuries/Surgeries/Serious Illnesses	Date

Please list any medications you are currently taking and the condition(s)

Medication	Condition	Dosage

Have you taken any pain-killers, anti-inflammatory, muscle relaxants or mood altering medications in the past 2 hrs?

□ **No** □ **Yes** What and how much? _____

For Office Use:	Updated:_____
Updated:_____	Updated:_____
Updated:_____	Updated:_____
Updated:_____	Updated: _____

(Please see reverse side)

Please Indicate the conditions that you have experienced or experiencing

Cardiovascular
- □ High blood pressure
- □ Low blood pressure
- □ Chronic congestive heart failure
- □ Heart attack
- □ Phlebitis/Varicose veins
- □ Stroke/CVA
- □ Pacemaker or similar device
- □ Heart disease
- □ Dizziness/Vertigo
- □ Seizures

Is there any family history of any of the above? □ Yes □ No

Head and Neck
- □ History of headaches
- □ History of migraines
- □ Vision problems
- □ Vision loss
- □ Hearing problems
- □ Hearing loss

Infectious Conditions
- □ Skin condition
  Describe:_____
  _____
- □ Respiratory conditions
  Describe: _____
- □ Hepatitis □ A □ B □ C □ D □ E
- □ HIV
- □ TB
- □ Herpes

Skin Conditions
- □ Eczema
- □ Psoriasis
- □ Rash
- □ Warts
- □ Open sores

Respiratory
- □ Asthma
- □ Bronchitis
- □ Emphysema
- □ Chronic cough
- □ Shortness of breath

Is there any family history of any of the above? □ Yes □ No

Muscle/Joint
- □ Neck
- □ Spine
- □ Upper back
- □ Mid back
- □ Lower back
- □ Shoulders
- □ Elbow
- □ Wrist/Hand
- □ Hip
- □ Knee
- □ Ankle/Foot
- □ Internal pins/Wires
- □ Artificial joints/Special equipments
  Describe:_____
  _____

Women
- □ Pregnancy
  Due date:_____
- □ Previous pregnancy complications:_____
  _____
- □ Menopausal problems:_____
  _____
- □ Menstrual problems:_____
  _____
- □ Any gynecological conditions:_____
  _____

Digestive
- □ Constipation
- □ Chrones disease
- □ Colitis
- □ Irritable bowel syndrome
- □ Ulcers

Other
- □ Loss of sensation
  Where? _____
  _____
- □ Diabetes
  Since when?_____
  Type _____
- □ Allergies
  What?_____
- □ Hypersensitivity
  What?_____
- □ Cancer
  Type/Location:_____
  _____
- □ Arthritis
  Type?_____
  Family history? □ Yes □ No
- □ Nerve lesion
- □ Any Nerve related diseases
- □ Epilepsy
- □ Hemophilia
- □ Fibromyalgia
- □ Chronic fatigue
- □ Scoliosis
- □ Polio/Post polio
- □ Osteoporosis
- □ Gout
- □ Any other diseases
  Describe: _____
  _____
  _____

Have you had Massage Therapy / Physiotherapy / Chiropractic before? □ No □ Yes
Did a healthcare practitioner refer you for Massage Therapy / Physiotherapy or Chiropractic? □ No □ Yes
If Yes, please provide their contact information: _____

Overall, how is your general health? _____

Is there any additional information that you would like to provide?
_____
_____
_____

_____ _____
Signature **Date**

Therapy One
NATURAL HEALTH CENTRE

Confidentiality and Consent:

By signing this form, you have agreed that you understand that all information gathered for this treatment remains confidential except as required or allowed by law or to facilitate assessment or treatment. You also agree that you understand that the therapist may discuss my case with peers who are under the same confidentiality clause in order to provide the best treatment possible. No other personal information will be disclosed other than that which is directly associated with your care / treatment.

Your written consent will be required should any information be released to any third party, e.g. insurance companies, family physician.

Please read the following:

☐ I have filled out a complete and updated Patient Health History form and have had an opportunity to ask any questions that I may have to clarify and better understand why an accurate health history is needed.

☐ My therapist has explained to me what the nature and purpose of the proposed assessment/ reassessment, treatment and or remedial plans, prior to the commencement of treatment. I understand that results are not guaranteed.

☐ I am aware that I may discontinue the assessment, reassessment, treatment, and/or remedial exercise plan at any time.

☐ I understand and am informed that the practice of Physiotherapy, Chiropractic Care and/or Massage Therapy involves some risks to treatment, including, but not limited to, pain and soreness. I understand that my therapist will, at the best of his/her abilities, explain expected benefits of the proposed treatment, as well as anticipate and inform me of any possible risks and complications.

☐ I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, provincial, or federal agency attempting to gather information without so stating.

☐ I understand the fee structure posted at the clinic and accept full responsibility for prompt payment.

☐ **Being late for the scheduled appointment will result in a shorter treatment and I will be responsible to pay for the scheduled time period. I also understand that scheduled treatment time includes treatment preparation, interview, assessment and documentations required by regulatory body and/or insurance companies so that I do not expect hands on treatment for the entire scheduled time period; however the therapist will try his level best to provide maximum hands on treatment within the time frame.**

☐ **I understand that I am responsible for paying the full appointment fee if I do not give 24 hours notice of change or cancellation.**

I,_____(Print Name) have read the above consent. I have also had an opportunity to ask questions about its content and by signing below I give my consent to the therapist to proceed with assessment, re-assessment, treatment, and or remedial exercise plan. I intend this consent to cover the entire course of treatment for my present condition. I also consent to add my email to our newsletter campaign.

_____ _____
Signature Date

I would like to settle the assessment / treatment fees via Direct Third-Party Billing:
☐ **No** ☐ **Yes** (Please fill out the Authorization of Payment Form)

Massage Therapy Clients please proceed to the next page

Therapy One

NATURAL HEALTH CENTRE

Fill this page only if your massage therapy treatment or assessment includes any of the following sensitive areas

1) Breast/Chest 2) Chest/Breast wall 3) Inner thigh 4) Glutes (Buttocks)

Massage therapy consent to asses and treat sensitive areas

I ____ (print Name) voluntarily give my consent to the therapist to Proceed with the assessment, re-assessment and treatment of sensitive areas and I am aware that the therapist will be working on the following areas of my body:

Please initial next to the body part:

_____ Breast/Chest _____ Chest/Breast Wall _____ Inner Thigh _____ Glutes (Buttocks)

I further understand the clinical reason of the assessment and treatment, draping method used, expected benefits and potential risk/side effects, alternative course of action, consequences of not having treatment or assessment. I also understand this consent is voluntary and can be withdrawn at any time.

Signature_______________________________ Date____________________

Date	Signature	Date	Signature	Date	Signature
____/____/____		____/____/____		____/____/____	
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