

Balanced Health Care

chiropractic . massage therapy . homeopathy . custom orthotics . customized training & rehab

Patient Name: _____ Date: _____

Home Address: _____ Postal Code: _____

Date of Birth: (E.g. = 01, January, 2005) _____ Age: _____ Gender: F M

Home Telephone: (____) _____ Work/Cell Telephone: (____) _____
Can we leave a message here? Y N Can we leave a message here? Y N

Email: _____ Occupation: _____

How did you find us / who referred you to us? _____

Person to contact in case of emergency: _____ Relation: _____

Telephone: (____) _____

Family Physician: _____ Family Physician's #: _____
May we contact him/her? Y N

Have you had previous imaging for this (Eg. x-ray, CT scan, MRI): _____

Is this a WSIB case: Y N Is this a Motor Vehicle Collision: Y N
Date of Accident: (MM/DD/YY) _____ Date of Collision: (MM/DD/YY) _____

What brings you to our office today? How long have you had this complaint? Has this happened before?

What is this injury/condition preventing you from doing?

Grade the intensity of your pain NOW	0	1	2	3	4	5	6	7	8	9	10
Grade the intensity of your WORST pain	0	1	2	3	4	5	6	7	8	9	10
Grade your level of stress	0	1	2	3	4	5	6	7	8	9	10

Please circle the following treatments (if any) that you have received for your complaint:

medication acupuncture massage physiotherapy
chiropractic other: _____

Current medications and/or supplements? _____

List any falls and/or accidents: _____

Operations, internal medical plates, pin, and/or artificial joints? _____

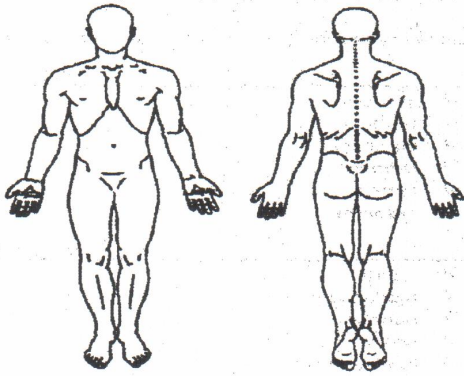
What do you expect from your visit at our clinic: _____

Name

Signature

Date

HEALTH STATUS SURVEY



Please mark the area(s) of complaint using the appropriate symbols:

Numbness or tingling	o o o o o
Pins & Needles	: : : : :
Burning	x x x x x
Dull or aching	/ / / / /
Stabbing	+ + + + +
Stiff or tight	2 2 2 2 2

Please **circle (o)** any conditions or symptoms **presently** causing you problems.
Please **check (✓)** any conditions or symptoms which have been a **problem in the past**.

NEUROLOGICAL

- Concussion
- Headache
- Epilepsy
- Fever/Sweats
- Fainting/Dizziness
- Clumsiness
- Numbness/tingling
- Weakness
- Loss of strength
- Nervousness
- Loss of weight
- Trouble sleeping

MUSCLES & JOINTS

- Neck
- Back
- Hip
- Knee
- Ankle
- Leg
- Foot/Toes
- Shoulder

- Elbow
- Wrist
- Arm
- Hand/Fingers
- Swollen joints
- Arthritis
- Fibromyalgia

E.E.N.T.

- Blurred/failing vision
- Double vision
- Eye pain
- Deafness
- Earache
- Ringing/buzzing
- Frequent colds
- Sinus infection
- Enlarged glands
- Thyroid problems
- Slurred speech
- Difficulty swallowing

SKIN

- Rashes/ Hives
- Allergies
- Itching/Dryness
- Bruise easily
- Other _____

RESPIRATORY

- Chronic cough
- Asthma
- Phlegm
- Coughing up blood
- Difficulty breathing

CARDIOVASCULAR

- Heart attack
- Cong. heart failure
- Stroke
- Bleeding disorder
- High blood pressure
- Low blood pressure
- Chest pain/Angina
- Hardened arteries

- Ankle swelling
- Poor circulation
- Pacemaker

GASTROINTESTINAL

- Poor appetite
- Excessive hunger
- Indigestion
- Nausea/vomiting
- Pain over stomach
- Constipation
- Diarrhea
- Hemorrhoids
- Gallbladder
- Ulcer
- Diabetes (onset: _____)

GENITOURINARY

- Trouble starting urinating
- Pain with urination
- Blood in urine
- Kidney infection

FAMILY HISTORY

Please indicate any members of your family (including yourself) who presently have or have had any of the following?

Cancer:

Heart Disease:

Diabetes:

Arthritis:

Osteoporosis:

For men...

- prostate trouble

For women...

- Painful menstruation
- Excessive flow
- Hot flashes
- Irregular cycle
- Cramps/backache
- Lumps in breasts
- Breast tenderness

SMOKING

Do you currently smoke? Y N

Did you ever smoke? ____ year(s)

pregnancies: _____

children: _____

Currently taking birth control? Y N

Have you in the past? Y N

Please be advised that if you see more than one practitioner in our office, your health information will be shared only with the practitioners providing treatment to you. All information on these forms and in your file is confidential except as required or allowed by law or to facilitate diagnosis or treatment. You will be asked to provide written authorization for release of any information. If your health status changes in the future, please let us know.

Informed Consent Form for Massage Therapy

This record of consent will be maintained confidentially in your file and is required before any new treatment can commence.

Massage Therapy includes the assessment and treatment of the soft tissues and joints of the body, by means of any, or some of, the following: soft tissue manipulations, joint mobilization, hydrotherapy, remedial exercise programs, and directed self-care programs.

Please read the following and check if fully understood:

- All massage treatments, information, and records will be safeguarded and remain confidential.
- In the event that client information needs to be shared, written consent will be first acquired from the client.
- The integrity of each client is respected. Thus:
 - Privacy for undressing/ dressing will be assured. Removal of clothing to your comfort level is recommended
 - Proper draping will be provided to assure security and privacy. Only the body part being treated will be undraped, leaving the remainder of the body fully draped at all times.
 - The therapist will use a pain scale from 0 to 10 and should not exceed a pain of level 7. (0 is described as having no pain and 10 is described as the most excruciating pain possible). Communicate with the therapist to ensure that he knows your level of comfort during the entire session.
- Promptness is required for appointment times. In the event of lateness, the massage may be cut short. Fees will be maintained as per the schedule.
- Cash or personal cheques accepted for payment at time of treatment. Receipts will be issued.
- The client may refuse, modify, or terminate treatment at any time, regardless of prior consent given.
- The therapist may refuse to treat any client or part of their body with just and reasonable cause.

I, _____, have read and understand the information contained in this form and consent to be treated for conditions discussed with the therapist today.

Date: _____

Client Signature: _____

Therapist Signature: _____