Health History Form

Accurate health history form is important to ensure that it is safe for you to receive an effective treatment. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate your treatment. You will be asked to provide a written authorization to release of any information.
Collection and storage of all information complies with the requirements of the Regulated Health Professionals Act and the Personal Information Protection and Electronic Documents Act. All your clinical records are stored on a secured and encrypted hard drive.

Name: _____Phone#:_____
Address: _____City:_____Prov:_____Date of Birth:_____
E-mail:_____ Occupation: _____
Emergency Contact:_____Phone#:_____ Relation:_____
How did you hear about us:_____
If a health care practitioner referred you, please provide their name and address:

_____

If you are currently receiving other health care for your main health concern, can you please specify?

_____

What are you main health concerns in order of importance to you?

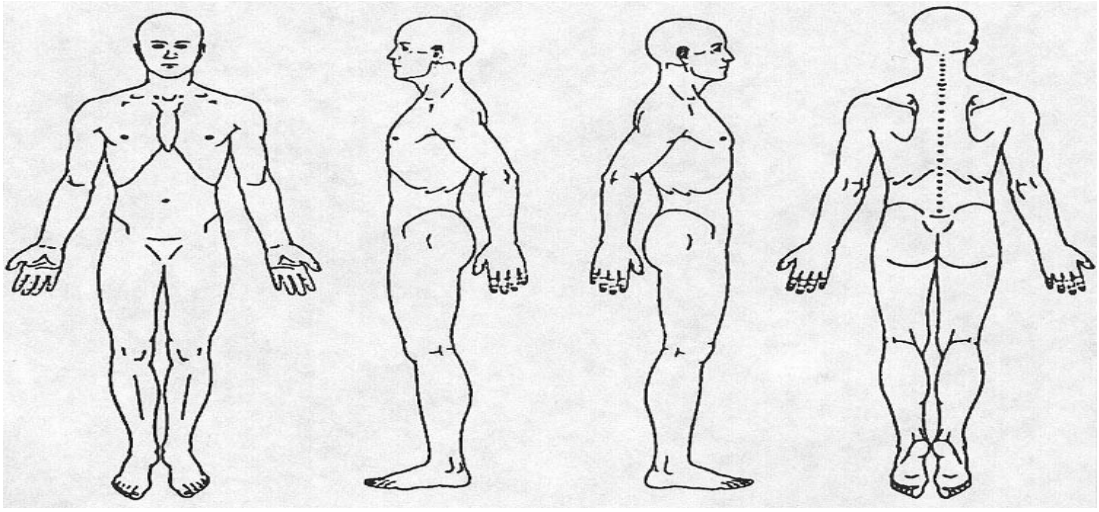
_____

_____

Visual Pain Rating Scale

Please mark a spot along the like that you think represents your level of pain today.
No Pain_____As bad as it can be

On this diagram please indicate all areas of your discomfort.



Prescription Drugs

_____

_____

Medical History

Please list any surgeries and when they occurred.

_____

_____

Please list any fractures and when they occurred

_____

_____

Please list any major accidents (including car accidents) and when they occurred.

_____

_____

Please list any allergies that you have.

_____

Have you ever been knocked unconscious or taken significant blow to the head? Please indicate when.

_____

Please list if you have any artificial joints, pins, pacemakers, etc...

_____

In the lists bellow please indicate with **X** if you are currently experiencing, or with **P** if you had it before.

General Conditions

☐ Loss of Consciousness
☐ Fainting/Dizziness
☐ Headaches/Migraines
☐ Seizures
☐ Insomnia/Poor Sleep
☐ Chronic Fatigue
☐ Anxiety
☐ Depression
☐ Sudden loss of weight
☐ Hyperglycemia
☐ Hypoglycemia
☐ Chronic Infection: Hepatitis, HIV, etc_____
_____
☐ Cancer_____
☐ Other Chronic Conditions: _____
_____

Genitourinary

☐ STD
☐ Trouble Urinating
☐ Blood in Urine
☐ Kidney Disease/Infection
☐ UTI
☐ Prostate

Skin

☐ Psoriasis
☐ Eczema
☐ Bruise easily
☐ Other: _____
_____

Muscles and Joints

List areas and/or joints that bother you (Ex.: neck, elbow)

_____
_____
_____

☐ Arthritis_____

Ears Nose Throat

☐ Eye Pain
☐ Vision Problem_____
☐ Earache
☐ Loss of Hearing
☐ Ringing in the Ears (tinnitus)
☐ Speech Problems_____
☐ Difficulty Swallowing
☐ Hyper/Hypo Thyroid_____

Gastrointestinal

☐ Excessive or Poor appetite
☐ Indigestion/Abdominal Pain
☐ Ulcers
☐ Belching or gas
☐ Frequent Nausea
☐ Constipation
☐ Diarrhea
☐ IBS
☐ Colitis
☐ Chron's disease
☐ Celiac disease
☐ Hernia:_____

Respiratory

☐ Asthma
☐ Sinus Problems
☐ COPD/Emphysema
☐ Chronic Cough
☐ Chest Pain/Tension
☐ Difficulty Breathing
☐ Bronchitis
☐ Pneumonia
☐ Other_____

Cardiovascular

☐ Heart attack
☐ Anemia
☐ Stroke/cardiovascular accident
☐ High Blood Pressure

☐ Low Blood Pressure
☐ Angina
☐ Bleeding disorder
☐ Varicose Veins
☐ Hardening of arteries
☐ Swelling of Ankles
☐ Circulation problems_____
_____

Female

☐ Pregnant, due_____
Number of Births_____Pregnancies_____
☐ Gynecological conditions:_____
_____
_____

Infection Control Protocols

Clinic infection control protocols are required by the Ministry of Health (MoH), the colleges that regulate health professionals, and associations for non-regulated professionals. If you have any questions about any of these protocols please ask.

The protocols that directly involve you include:
Providing hand-washing and/or hand-sanitizing upon entry/exit of the clinic. It is required that all persons who enter the clinic must wash or sanitize their hands.
The therapist must wash or sanitize their hands prior to the beginning of treatment.
Signage in all areas instructing all clients and visitors to wear a mask. It is required that all persons who enter the clinic must wear masks. If masks cannot be tolerated an individual risk assessment will be conducted, but may mean that treatment will be postponed.
Clear, visible signage at all entrances and within the clinic outlining information about the virus and how to limit transmission.
COVID-19 Screening at time of booking (virtually) and at time of treatment. The therapist will also be required to complete the screening on themselves prior to each treatment.

Treatment Information

Treatment consists of collection of complaint information, health history, verbal and physical assessment, manual (hands-on) therapy, rehabilitation information and exercise instruction.

You can wear comfortable clothing. Some techniques may involve body contact with the use of barriers such as clothes, pillows, or towels. Sensitive areas that may be contacted include the pelvis, chest and inner thighs, excluding private areas. If you do not want any areas of your body contacted for any reason please tell us at any time.

All aspects of treatment require ongoing verbal consent. Please note that you may withdraw your consent and discontinue any aspect of/or all treatment at any time without explanation. Your consent is voluntary and ongoing throughout the treatment, and can be withdrawn for part or all of the treatment at any time, without explanation or consequence.

Consent

I agree that it is my choice to receive manual treatment. I understand that the treatment will involve body parts as described above, and I agree to communicate with my therapist at any time if I feel that my well-being is being compromised. The therapist will be open to any questions about the treatment and I can stop the treatment at any time.

I understand that manual therapists do not diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical treatment or pharmaceuticals. I acknowledge that manual therapy is not a substitute for medical examination or diagnosis, and that it is recommended that I see my primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update my therapist of any changes in my health status. I understand that this treatment is not covered by OHIP. The therapist is not responsible for any billings or dealings with private health insurance companies. However, the receipt describing the details of the treatment as well as the therapist's credentials will be issued.

Signature

I attest that I have read the above information and that information provided in this form is true and accurate to the best of my knowledge.

Signature_____ Date: _____

Please read and initial that you have read the following

I understand that I will be charged full price for missed appointments, appointment modifications or cancelled appointments, if I do not provide at least 24 hours' advanced notice. Please initial here that you have read and understood this billing agreement.

Initials: _____