

Medical History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

PLEASE PRINT

Name: _____ Phone # (H) _____ (B) _____
Address: _____
Date of Birth: _____ Occupation: _____ Source of referral _____
What is your chief complaint? _____ How is your health in general? _____

Please indicate conditions you are experiencing or have experienced:

HEAD

- headaches
- migraines
- vision problems/loss
- earaches/hearing loss
- jaw problems

MUSCLES/JOINTS

- neck
- mid-back
- lower back
- shoulders
- leg: left/right
- other: _____

OTHER CONDITIONS

- digestive problems
- constipation
- epilepsy
- loss of sensation
- liver/gall bladder problems
- kidney problems
- diabetes
- allergies/hypersensitivity reaction
- cancer
- arthritis
- hemophilia
- osteoporosis
- mental illness
- internal pins, wires, artificial joints or special equipment
where? _____
- other: _____

RESPIRATORY

- smoking
- chronic cough
- emphysema
- asthma
- bronchitis
- shortness of breath

INFECTIONS

(Hepatitis, TB, HIV, AIDS and other)

SKIN CONDITIONS

SURGERY

type: _____
date: _____
current symptoms: _____

CURRENT MEDICATION

name _____ use _____

CARDIOVASCULAR

- high blood pressure
- low blood pressure
- chronic congestive heart failure
- history of heart disease/MI
- phlebitis/varicose veins
- stroke/CVA
- pacemaker or similar device
- heart attack
- other: _____

INJURY

type: _____
date: _____
current symptoms: _____

MEDICAL DOCTOR

Name: _____
Address: _____
Phone #: _____

I understand that the information I give on this form will be confidential and will be used for no other purpose than medical professional's clinical records. The information given by me on this form is accurate to the best of my knowledge, and I understand that will be used by the medical professional in determination of treatment which is appropriate for me. It is my responsibility to update this information as it changes.

Date: _____

Signature: _____

Consent to Osteopathy

Date of birth: _____ M _____
F _____

I, _____ of my own free will, consent to be treated for the following condition: _____

I acknowledge that my osteopath has provided me with such information as is pertinent to the treatment for above listed complaint. Alternative courses of treatment (where applicable and relevant) have been explained to me, as well as the possible benefits, risks, and side effects, if any, with regard to my osteopath's proposed treatment plan.

I feel that I fully understand what is involved in the proposed treatment and what the possible consequences of not having treatment may be.

I acknowledge that, for the purpose of integrated osteopathy, the following areas may be addressed during the course of treatment: head, neck & shoulders, upper chest, arms, back & hip, abdomen, buttocks, legs, hands & feet (breasts are excluded unless specifically indicated for clinical reasons, in which case a separate consent form will be discussed & signed).

These are the areas of my body that I give permission to be addressed during the course of a osteopathy treatment: (please indicate your choices)

head neck/shoulders upper chest arms back/hips
 abdomen buttocks legs hands/feet all of the above

I understand that I may change my mind regarding any aspect of my treatment at any time, and, upon informing my osteopath of my decision, I may withdraw consent with the intent to alter or discontinue treatment.

In compliance with the "Consent to Treatment Act", I provide my full, voluntary, informed consent to treatment.

Client signature: _____

Osteopath name: _____

Date: _____

PATIENT SIGN IN SHEET

Therapy: _____

Name: _____

Address: _____

D.O.B. _____

SESSION	DATE	TIME	PATIENT'S SIGNATURE
1			
2			
3			
4			
5			
6			
7			
8			
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10			
11			
12			
13			
14			
15			
16			

HEALTH QUESTIONER

NAME

DO YOU CURRENTLY HAVE:

YES NO

High Blood Pressure
Heart Disease
Respiratory Condition (i.e. Asthma)
Diabetes
Pacemaker
Epilepsy
Allergies or Sensitivities (i.e. to heat, cold, drugs, tape...)
Metal Implants (i.e. pins, screws, plates, hearing aid, IUD)

HAVE YOU EVER HAD:

YES NO

Physiotherapy		
If yes, when?	Why?	
Surgery or Tumors		
If yes, give details:		
Serious Illness		
If yes, give details:		
Recent X-Ray		
If yes, when?	What body part?	

ARE YOU NOW:

YES NO

Pregnant		
Receiving any other treatment (i.e. massage, acupuncture, chiro, chemotherapy, radiation, etc.)		
If yes, give details:		
Taking any medication		
If yes, give details:		

OTHER COMMENTS:

SIGNATURE

DATE _____

Consent toAcupuncture Treatment

Date of birth _____

M _____

F _____

I, _____ of my own free will, consent to be treated for the
(name)
following condition: _____
(description of condition /major complain)

I acknowledge that my therapist has provided me with such information as is pertinent to the treatment for above listed complaint. Alternative courses of treatment (where applicable and relevant) have been explained to me, as well as the possible benefits, risk, and side effects, if any, with regard to my therapist's proposed treatment plan.

I feel that I fully understand what is involved in the proposed treatment and what the possible consequences of not having the treatment may be.

I acknowledge that, for the purpose of integrated therapy, the following areas may be addressed during the course of treatment: head, neck & shoulders, upper chest, arms, back & hip, abdomen, buttocks, legs, hands & feet (breasts are excluded unless specifically indicated for clinical reasons, in which case a separate consent form will be discussed & signed).

These are the areas of my body that I give permission to be addressed during the course of a massage treatment: (please indicate your choices)

head neck/shoulders upper chest arms back/hips
 abdomen buttocks legs hands/feet all of the above

I understand that I may change my mind regarding any aspect of my treatment at any time, and, upon informing my therapist of my decision, I may withdraw consent with the intent to alter or discontinue treatment.

In compliance with the "Consent to Treatment Act", I provide my full, voluntary, informed consent to treatment.

Client signature: _____

Therapist Name: _____

Date: _____

A & A Medical Centre
555 Finch Ave. West
Toronto, ON
M2R 1N5

Informed Consent for Social Work

I hereby acknowledge and provide my informed consent for Social Work treatment with the understanding that Social Worker will provide my treatment be it individual, couples or family.

I acknowledge that Social Worker has provided me with such information that is important to the treatment.

I understand that I may change my mind regarding any aspect of my treatment at any time, and, upon informing A & A Medical Centre of my decision, I may withdraw consent with the intent to alter or discontinue treatment.

In compliance with the "Consent to Treatment Act", I provide my full, voluntary, informed consent to treatment.

Client name: _____

Client signature: _____

Date: _____

Social Worker: Mila Marie Zivkovic, RSW

ADULT PERSONAL HISTORY (18 AND OLDER)

CLIENT NAME: _____

DATE: _____

Please take your time and answer the questions on this form. The information will help your Social Worker understand you better. All information on this form is confidential.

MARTIAL STATUS:

Unmarried _____
Live together _____
Married _____
Separated _____
Divorced _____
Widowed _____

Family members you are close to now: _____

What RECENTLY HAPPENED to make you decide to seek help now? _____

What would you like this clinic to do for you? _____

CIRCLE or CHECK any of the following that apply to you now or within the past month (feel free to explain):

Hopelessness	Increased alcohol use	Nervous/Anxious
Loneliness	Financial worries	Mood swings
Loss of appetite	Loss of control in: -sleeping	Not seeing friends

Please explain circled items: _____

INTERESTS/ACTIVITIES (Circle or check):

Television	Being with friends	Shopping
Listening to music	Being with family	Exercise
Reading	Cooking/eating	Playing sports

Other interests/activities: _____

Have you recently lost interest in activities you normally enjoy? _____

Date of last physical: _____

Client Name: _____

Client Signature: _____

PATIENT SIGN IN SHEET

Confirmation of Services

Name _____ hereby

Acknowledge receiving Massage Therapy treatment on following days.

N/N	Date	Treatment	Duration	Patient Signature
1		Massage Therapy	min.	
2		Massage Therapy	min.	
3		Massage Therapy	min.	
4		Massage Therapy	min.	
5		Massage Therapy	min.	
6		Massage Therapy	min.	
7		Massage Therapy	min.	
8		Massage Therapy	min.	
9		Massage Therapy	min.	
10		Massage Therapy	min.	
11		Massage Therapy	min.	
12		Massage Therapy	min.	
13		Massage Therapy	min.	
14		Massage Therapy	min.	
15		Massage Therapy	min.	

MASSAGE THERAPY

HEALTH HISTORY FORM

For your information:

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: _____	Date: _____
Address: _____	Tel: res _____ bus _____
Date of birth: _____ Occupation: _____	Fax/email: _____
Who referred you? _____ Their Address? _____	What is your primary complaint? _____

Health History: Please indicate conditions you are experiencing, or have experienced:

<p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> chronic cough <input type="checkbox"/> shortness of breath <input type="checkbox"/> bronchitis <input type="checkbox"/> asthma <input type="checkbox"/> emphysema <p>Cardio vascular</p> <ul style="list-style-type: none"> <input type="checkbox"/> high blood pressure <input type="checkbox"/> low blood pressure <input type="checkbox"/> CCHF <input type="checkbox"/> heart attack <input type="checkbox"/> phlebitis <input type="checkbox"/> stroke/CVA <input type="checkbox"/> pacemaker or similar device <p>Skin</p> <ul style="list-style-type: none"> <input type="checkbox"/> skin conditions 	<p>Other Conditions</p> <ul style="list-style-type: none"> <input type="checkbox"/> loss of sensation <input type="checkbox"/> diabetes (onset: _____) <input type="checkbox"/> allergies (ie. anaphylaxis) <input type="checkbox"/> epilepsy <input type="checkbox"/> cancer <input type="checkbox"/> arthritis <p>Head/Neck</p> <ul style="list-style-type: none"> <input type="checkbox"/> vision problems <input type="checkbox"/> vision loss <input type="checkbox"/> ear problems <input type="checkbox"/> hearing loss <p>Infections</p> <ul style="list-style-type: none"> <input type="checkbox"/> hepatitis <input type="checkbox"/> skin conditions <input type="checkbox"/> TB <input type="checkbox"/> HIV 	<p>Women</p> <ul style="list-style-type: none"> <input type="checkbox"/> pregnant (due: _____) <p>Soft tissue/joint discomfort and its nature</p> <ul style="list-style-type: none"> <input type="checkbox"/> neck <input type="checkbox"/> low back <input type="checkbox"/> mid back <input type="checkbox"/> upper back <input type="checkbox"/> shoulders <input type="checkbox"/> arms <input type="checkbox"/> legs <input type="checkbox"/> knees <input type="checkbox"/> other
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Current Medications: _____ Primary Care Physician: _____

Condition it treats: _____ Address: _____

Surgery: _____ date: _____ Present Involvement in Other Health care: Yes No

nature: _____ If yes, please specify: _____

Injury: _____ date: _____

nature: _____

Other Medical Conditions (e.g. digestive conditions, gynaecological conditions, hemophilia, etc.): _____

Of Special Note: (presence of internal pins, wires, artificial joints, special equipment): _____

CONSENT TO TREATMENT FOR MASSAGE THERAPY

Patient name: _____

Please print

Hereby consent to massage therapy treatment for
following complaints: _____

The therapist has thoroughly provided me with information relevant to the treatments for the above listed complaints.

My massage therapist has thoroughly explained alternative treatment where applicable and relevant, as well as possible risks and side effect of my therapist's proposed treatment plan.

The consequences of having treatments or not having treatments have been explained to me. I have been informed that I may stop treatment at any time.

At any given time throughout the treatment, I may request the therapist to stop, modify or change the treatment plan.

I have read the above and understand the consent to Massage Therapy treatment.

Patient's Signature

Date

Therapist's Signature

Consent form to release information

I, (name) _____

Please print

Hereby consent to release of my medical information and records to insurance company.

I have received explanation of what that includes.

Patient signature _____

Date _____

PATIENT SIGN IN SHEET

Therapy: _____

Name: _____

Address: _____

D.O.B. _____

SESSION	DATE	TIME	PATIENT'S SIGNATURE
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RE-ASSESSMENT

Patient's Name: _____

, Date of Birth: _____

(DD/MM/YY)

Current Condition*If you have a specific condition, please complete the questions, otherwise go on to the next section of this form.*

What is your major complaint? _____

How long have you had this condition? _____

Did it begin:

- Suddenly
- Gradually

Is the condition:

- Getting worse
- Getting better

 Consistent Comes and goes

Is there pain:

- At night
- On coughing or sneezing

Describe if the pain travels: _____

Please mark your area(s) of concern using the symbols that you feel best describe what you are experiencing:

Numbness -----

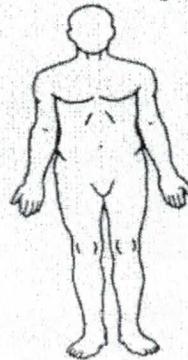
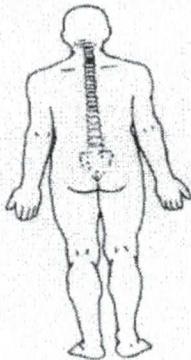
Burning #####

Stabbing ++++++

Pins & Needles :::::::

Aching *** *

Stiff / Tight //////////////



Place an "X" on the line to indicate the amount of pain/discomfort associated with your condition:

No Pain [0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10] Worst Pain Ever

What activities or positions cause aggravation: _____

What activities or positions provide relief: _____

Please describe any past episodes: _____

If there was an injury or event that lead up to this condition, please describe. _____

If any health practitioner has previously treated you for this condition, please specify:

Location: _____ When: _____ Nature of Treatment _____

Can we follow up? (Please circle) Yes No

Has anyone else in your family had a similar complaint? _____

Other areas of concern: _____

Previous injuries: _____

Informed Consent to Chiropractic &/OR Acupuncture Treatment

CHIROPRACTIC

Doctors of Chiropractic, medical doctors, and physical therapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there may be some risks associated with such treatment. In particular you should note:

- a) While rare, some patients have experienced rib fractures, or muscle and ligament strains or sprains following spinal adjustments.
- b) Some types of spinal adjustments of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. We employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury.
- c) There have been rare reported cases of disc injuries following cervical or lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustments, has been the subject of government reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective in treating spinal pain, headaches and other symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

ACUPUNCTURE

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, and stuck or bent needles.

I have been advised that only sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

PLEASE READ BEFORE SIGNING

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of the chiropractic &/or acupuncture treatment (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic &/or acupuncture treatments offered or recommended to me by my chiropractor (including spinal adjustment).

Date

(Print Name)

(Sign - patient, or guardian)

Witness

PATIENT ENTRANCE FORM

Date _____ Circle: Male _____ Female _____
Name _____ Birth Date (dd/mm/yy) _____ Age _____
Address _____ Apt # _____ City _____ Province _____
Postal Code _____ Home # _____ Cell # _____
Work # _____ E-MAIL _____
Occupation _____ Employer _____
Name of Emergency Contact _____ Contact # _____
How were you referred to our office ? (include NAME) _____

Family Dr and # _____ Last physical exam date _____
Surgeries or illnesses (include dates) _____
Fractures or past injuries (includes dates) _____
Medications _____
X-RAYS taken: Yes No Date _____ Results _____
Have you been treated for any health condition by a physician/chiropractor in the last year? Yes No
If yes, describe _____

Extended Health Care Company _____
Do you need any help retaining information about your health insurance coverage? Yes No

AUTHORIZATION AND RELEASE

I authorize the doctor to release all information necessary to communicate with personal healthcare providers.

PAYMENT POLICY

I understand that payment is due at the time professional services are rendered to me. I understand that I am responsible for all costs of treatment care, regardless of insurance coverage.

MISSED APPOINTMENT POLICY

There is a \$10 fee for missed appointments without any notification. Our office does not charge for cancelled appointments, but requests 12 hours notice to reschedule an appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____

Name: _____

HEALTH HISTORY

Please indicate whether you have experienced any of the following relating to your current condition:

Fever / Chills	_____	Allergies	_____	Shoulder/Elbow/Hand Pain	_____
Headaches	_____	Arthritis	_____	Hip/Knee/Foot Pain	_____
Migraines	_____	Loss of Balance	_____	Numbness in Fingers	_____
Stiff Neck	_____	Loss of Taste	_____	Numbness in Toes	_____
Neck Pain	_____	Loss of Smell	_____	Shortness of Breath	_____
Back Pain	_____	Difficulty Urinating	_____	Chest Pain / Tightness	_____
Tension	_____	Unusual Bowel Patterns	_____	High Blood Pressure	_____
Nervousness	_____	Hands Cold	_____	Indigestion Problems	_____
Irritability	_____	Feet Cold	_____	Weight Loss / Gain	_____
Dizziness	_____	Sinus Problems	_____	Diabetes	_____
Fainting	_____	Ringing in Ears	_____	Joint Pain / Swelling	_____
Weakness	_____	Depression	_____	Fatigue	_____
Muscle Spasms	_____	Sleeping Problems	_____	Loss of Memory	_____

Women: Menstrual Difficulties _____

Are you pregnant? _____

Date of Last Period _____

Date of Last Pap _____

Date of Last Mammogram _____

SOCIAL HISTORY

Please indicate whether you engage in these: **OFTEN = ✓** **SOMETIMES = S** **NEVER = X**

_____	Caffeine Intake	_____	Social Pressures
_____	Tobacco Use	_____	Financial Pressures
_____	Alcohol Use	_____	High Stress Activity
_____	Drug Use	_____	Other (please specify)
_____	Exercise	_____	_____

FAMILY HISTORY

Please indicate diseases and conditions that are current health problems of a family member.

Condition _____	Family Member _____	Age _____
Condition _____	Family Member _____	Age _____
Condition _____	Family Member _____	Age _____

Name: _____

PAIN DRAWING & SCALE

TELL US WHERE YOU HURT

Mark the areas on your body where you feel your pain. Include all affected areas. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > >

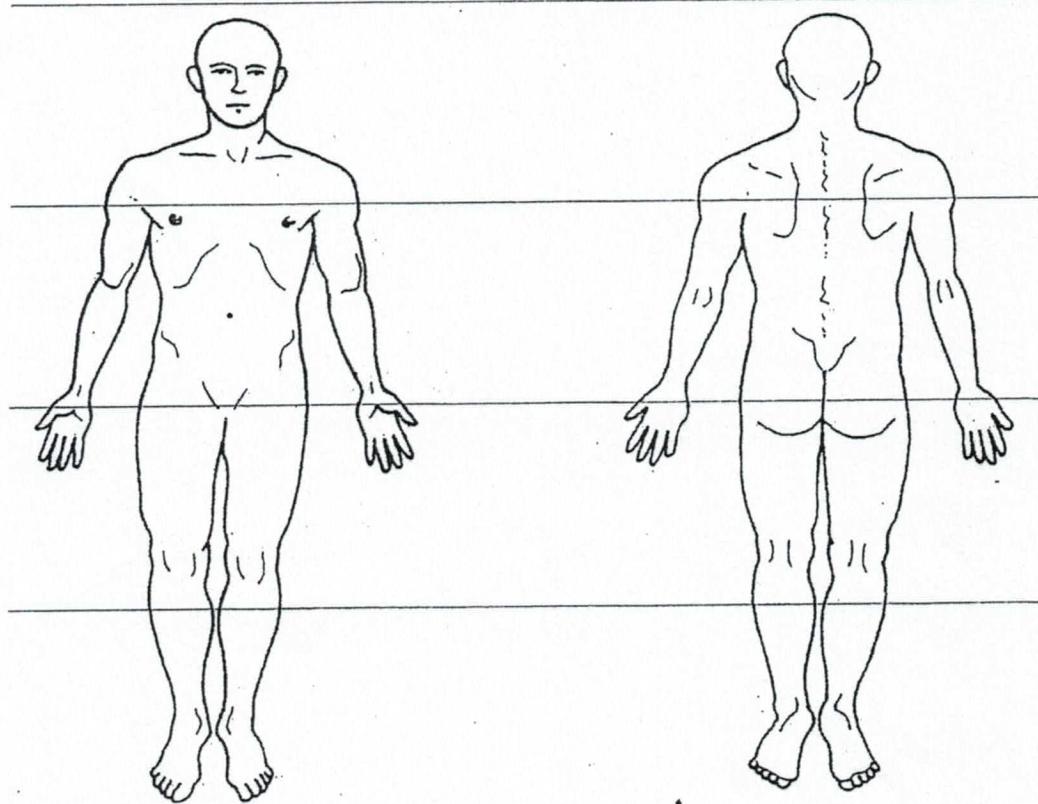
Burning x x x x x

Numbness = = = =

Stabbing / / / / /

Pins & Needles o o o o

Throbbing ~ ~ ~ ~ ~



TELL US HOW MUCH YOU HURT

On a scale of 0 to 10, please mark with an "X" the level of your pain today. 0 indicates no pain while 10 indicates the worst pain you have ever experienced.

0 1 2 3 4 5 6 7 8 9 10

Treatment notes for: _____

Date: _____ Time: _____ am pm Duration: _____ min./hr. Fee \$ _____

Informed consent received: treatment assessment Therapist: _____

Techniques Used:

Swedish frictions deep facial trigger points stretch intra-oral
 breast massage hydrotherapy joint mobilization grade: _____ other (list) _____

Areas Treated:

back neck shoulders face arm L R leg L R
 hip area abdominals chest breast other (list) _____

Clinical findings:

Clients reaction / feedback:

Recommended Self-Care:

Date: _____ Time: _____ am pm Duration: _____ min./hr. Fee \$ _____

Informed consent received: treatment assessment Therapist: _____

Techniques Used:

Swedish frictions deep facial trigger points stretch intra-oral
 breast massage hydrotherapy joint mobilization grade: _____ other (list) _____

Areas Treated:

back neck shoulders face arm L R leg L R
 hip area abdominals chest breast other (list) _____

Clinical findings:

Clients reaction / feedback:

Recommended Self-Care:

Date: _____ Time: _____ am pm Duration: _____ min./hr. Fee \$ _____

Informed consent received: treatment assessment Therapist: _____

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Areas Treated:

back neck shoulders face arm L R leg L R
 hip area abdominals chest breast other (list) _____

Clinical findings:

Clients reaction / feedback:

Recommended Self-Care:
