

Julie O'Connor, RMT [reg # L063]

The Health Loft

47 Stewart Street | Toronto ON M5V 2V8

o: 647 346 2281 f: 647 436 5547

www.thehealthloft.ca



Confidential Patient Information (please use BLOCK LETTERS)

Personal Details

Prefix: Dr Mr Mrs _____
Ms Miss Last Name First Name Initial(s)

Address City Province Postal Code

() - () - () - / /

Home Phone No. Work Phone No. Mobile Phone No. Date of Birth (mm/dd/yy)

Gender (M/F) Occupation e-mail address

Who referred you? _____

Health Information

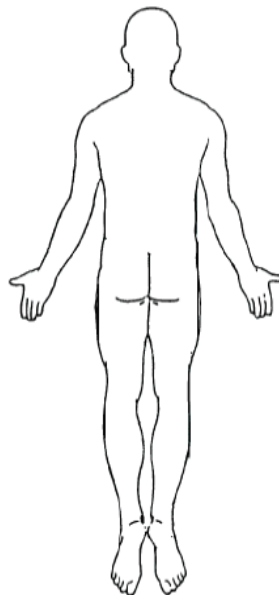
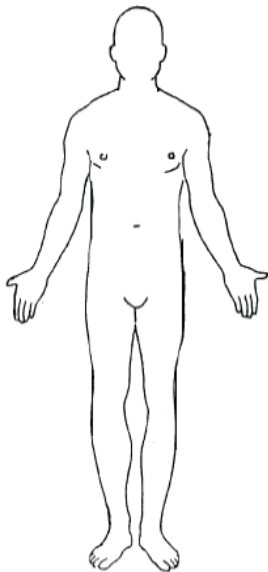
Name of Medical Doctor () - Telephone No. Address

Date of Last Appointment Date of Last Physical

Emergency Contact

Name Relationship () - () -
Daytime Phone Evening Phone

Pain Diagram



Please shade and code areas to indicate location of pain or discomfort.

- P – Pins & Needles
- N – Numbness
- S – Spasm
- T – Tenderness
- A – Aches
- R – Radiations
- B – Burning
- X - Stabbing



Symptoms

1. What is your principal problem or the one area of greatest pain?

2. Please rate the level of this pain on the following scale: 0 is no pain, 10 is extremely severe pain.
0 _____ 10
3. Do you think the pain has been getting worse? Yes / No
If so, how quickly has it increased? Gradually / Suddenly
4. What do you think caused this problem?

5. How often do you experience this pain?
 1-2 hrs per day About half the day Most of the day The pain is constant
6. How does the pain affect your daily activities?
 It does not affect them I have had to change how I do things
 I have had to stop doing some of them I am unable to perform most daily activities
7. What increases your pain? _____
8. What decreases your pain? _____
9. Have you experienced this problem in the past? Yes / No If so, when? _____
10. Which of the following treatments, if any, have you received for your complaint?
 Medication Physical Therapy Massage
 Chiropractic Acupuncture Other
11. Which of the above treatments have benefitted you the most?
 Medication Physical Therapy Massage
 Chiropractic Acupuncture Other
12. What do you expect from your visit to the clinic? _____
13. Do you have a pacemaker or any metal implants (e.g. screws)?
If so, explain: _____
14. List any other issues currently bothering you and rate the pain level for each.
a. _____ 0 _____ 10
b. _____ 0 _____ 10
15. Have you ever been involved in an auto accident? Yes / No
If Yes, when? _____
Were you injured? Yes / No If yes, complete the **Motor Vehicle Accident Form**
16. Have you ever been injured at work? Yes / No
If Yes, when? _____ If yes, please complete the **Workplace Injury Form**



Medical History / Other

1. Please list all medications you are currently taking (including vitamins and over the counter medication).
2. Please list all surgeries you have had with date(s). _____
3. Diet: Please rate your diet on the following scale: 0 = poor, 5 = healthy 0 _____ 5
Meals: ___ per day Tobacco: ___ cigarettes per day Alcohol: ___ drinks per week
Allergies / Other Dietary Concerns: _____
4. Exercise: _____ Cardiovascular: ___ x / week Weights: ___ x / week
5. If female, when was your last period? _____
6. If female, are you pregnant? Yes / No / Unsure
7. Below are several lists of diseases and conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care. Please check all that apply.

Diseases

- | | | | | |
|------------------------------------|--|--|--------------------------------------|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Anaemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis A B C D | <input type="checkbox"/> Influenza | <input type="checkbox"/> Mental Disorder(s) |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Smallpox | <input type="checkbox"/> Stroke / ITA |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other | _____ |

Cardiovascular & Pulmonary System

- | | | | | |
|-------------------------------------|---|---|--|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Ankle/calf swelling | <input type="checkbox"/> Irregular heartbeat |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood pressure | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Congestion | <input type="checkbox"/> Shortness of breath |

Gastrointestinal System

- | | | | | |
|--|---|---|--|--|
| <input type="checkbox"/> Abnormal appetite | <input type="checkbox"/> Gas / bloating | <input type="checkbox"/> Upset stomach | <input type="checkbox"/> Frequent nausea | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Weight trouble | <input type="checkbox"/> Gall bladder | <input type="checkbox"/> Constipation | <input type="checkbox"/> Dark / bloody stool |
| <input type="checkbox"/> Abdominal cramps | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Irritable bowel | | |

Genitourinary & Musculoskeletal Systems

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Bladder trouble | <input type="checkbox"/> Vaginal pain | <input type="checkbox"/> Breast pain/lumps | <input type="checkbox"/> Sexual dysfunction | <input type="checkbox"/> Difficulty chewing |
| <input type="checkbox"/> Joint pain/stiffness | <input type="checkbox"/> Menstrual cramps | <input type="checkbox"/> Vaginal infection | <input type="checkbox"/> Menstrual irreg'y | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Clicking jaw | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Discoloured urine | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Walking difficulties | <input type="checkbox"/> Pain b/w shoulders | <input type="checkbox"/> Wrist / hand pain | <input type="checkbox"/> Arm pain | <input type="checkbox"/> General stiffness |

Nervous System / EENT

- | | | | | |
|---------------------------------------|---|---|--|--|
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tingling | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Ears ringing | <input type="checkbox"/> Ears buzzing | <input type="checkbox"/> Stress | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Hearing difficulties | <input type="checkbox"/> Grinding teeth | | |

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature: _____

Date: _____

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Informed Consent to Massage Therapy Treatment

I, _____, understand Massage Therapy involves manipulating the soft tissues of the body in order to develop, maintain, rehabilitate, improve physical function, and to relieve pain.

During the treatment, I will remain draped, and the therapist will only undrape the area to be worked on (for example: back, legs, arms). I may opt to remain as clothed in accordance with my comfort levels.

I understand at any time before, during, or after treatment, the therapist will respect my communication, my request not to be touched in any particular area of the body, and if I wish to stop or modify the treatment.

I consent that The Health Loft is the guardian of my file wherein I, or my therapist can access it at a future time. I also understand this can help treatments consistent and safe in the event I see more than one therapist.

Information exchanged between my therapist and myself is confidential and requires my consent for release out of the clinic unless the therapist is legally obligated to do so.

I understand that accurate, and up-to-date health information and history is imperative to ensure a safe and effective treatment, and that I must notify The Health Loft as soon as any information changes.

I also understand that care by my therapist is not intended to replace medically necessary treatment, and that findings are not a diagnosis.

I understand the 24-hour cancellation policy, and I expect to be charged the full amount for sessions with less than 24 hours notice, unless another client can fill the time slot. I understand The Health Loft will enforce this policy respectfully with all clients.

I hereby consent to massage therapy as discussed between the therapist, and myself and agree that the health history I have provided is complete and accurate.

DATE: _____

SIGNATURE: _____

Update 1 _____ Update 2 _____ Update 3 _____ Update 4 _____



Financial Policy

Payment

- Payment for all services is due when rendered.

Cancellation Policy

- We would appreciate at least 24 hours notice if you are unable to keep your scheduled appointment. If we do not receive this notice then you may be responsible for the fee of the scheduled visit.

Non-Payment Procedures

- Should you have an appointment and leave the premises without making payment, we are entitled to charge the appointment fee to your credit card.

Credit Card Type _____

Credit Card Number _____

Name as it appears on Card _____

Expiry Date _____

I, _____, have read the above and understand that I am personally responsible for paying the fees for all services rendered. I authorize The Health Loft to charge any fees due as per the Financial Policy to the credit card information provided above.

Name _____

Signature _____

Date _____