CONFIDENTIAL PATIENT HISTORY FORM

SAFE, EFFECT IVE HEALTH CARE

Balance
NATURAL HEALTH CLINIC
3105 36th Avenue, Vernon, B.C.
250-545-0103

Name _____ **Birthdate** _____
(month / day / year)

Address _____ **Family Doctor** _____

_____ Phone _____

Postal Code _____ **Referring Professional** _____

Phone (home) _____ Phone _____

(cellphone) _____

(work) _____

Email _____ **Care Card #** _____

Extended Medical Insurer _____

Occupation _____ **ICBC** or **WCB?** ❑ **No** ❑ **Yes** Claim# _____

How did you hear about (Registered) Massage Therapy? _____

How did you hear about our clinic? _____

Please indicate if you believe any of the following apply to you? (P = past C = current) Circle if necessary.

_ Heart Attack
_ High / Low Blood Pressure
_ Stroke or Aneurysm
_ Pace Maker
_ Other Heart condition
_ Varicose Veins
_ Bruise easily
_ Other Circulatory condition
☐ Anxiety
_ Diabetes
_ Kidney Disease
_ Other Urinary condition

_ Headaches / Migraines
_ Dizziness / Fainting
_ Nausea
_ Spinal Injury
_ Head Injury
_ Epilepsy / other seizures
_ Other Neurological condition
☐ Depression
_ Asthma
_ Chronic Sinusitis
_ Other Respiratory condition

_ Irritable Bowel / Colitis
_ Digestive condition
_ Skin condition

_ Joint Dislocation
_ Bone Fracture
_ Arthritis
_ Osteoporosis
_ Rods / Pins / Plates / Shunts
_ Implants _____
_ Transplant _____
_ Corrective Lenses/Contacts

_ Cancer _____
_ Hepatitis
_ HIV
_ Other Contagious condition
_____

Please list any Medications you presently take:

_____

_____

Known Allergies (including medications, foods, seasonal, oils and lotions, etc.)

_____

Do you have any family history of medical conditions? ❑ **Yes** ❑ **No**

Please list: _____

Have you ever been hospitalized, had any major accidents, illnesses, or surgeries? ❑ **Yes** ❑ **No**

Please comment: _____

_____

Continued

Other therapy / treatment: (past or present, does not have to be related to this visit)

Massage Therapy	Date of last visit	_____	Location	_____
Chiropractor	"	_____	"	_____
Physiotherapy	"	_____	"	_____
Naturopath	"	_____	"	_____
Acupuncture	"	_____	"	_____
Other _____	"	_____	"	_____

List any Activities, Sports, Hobbies
(ie. Jogging, Hockey, Crafts, Computer, etc)

_____

_____

_____

List any **NON-prescription vitamins, minerals or other supplements** you are taking:

_____

_____

_____

Please CIRCLE the answer closest to how you PRESENTLY feel: (1 = poor, 5 = excellent)

Quality of Sleep	1	2	3	4	5
Energy Level	1	2	3	4	5
Eating Habits	1	2	3	4	5
Stress Level	1	2	3	4	5
Exercise Habits	1	2	3	4	5

Hours of sleep per night (approx.) ___

Number of meals you regularly eat per day ___

Number of times you exercise per week ___

Smoker Yes No Occasional
Alcohol Yes No Occasional

Current Condition

Please describe your current condition & symptoms: _____

_____

_____

_____

How long have you had this condition? _____

How did it start? _____

_____

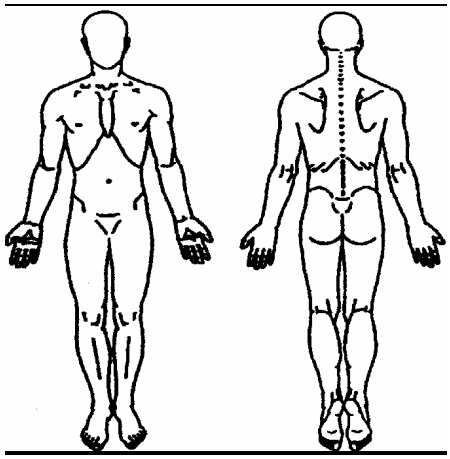
What aggravates it? _____

_____

What relieves it? _____

_____

Please indicate on the diagram the nature of your symptoms, using the symbols indicated:



Aching
Stabbing X X X
Shooting
Burning # # #
Numbness or Tingling

___ **Sharing of My Patient Record:** My initials confirm that I request and authorize my RMT to provide to the Clinic and to other health care practitioners who provide me with treatment, copies of any patient record created by my RMT. I understand this will enable the Clinic to maintain a complete patient record on my behalf. I understand that I may revoke this permission in writing at any time in the future.

Please Note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

I authorize the clinic and its associated RMTs to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated RMTs to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature: **Date:**

Balance
NATURAL HEALTH CLINIC

Cancellation/No Show Policy

Missed Appointments

When you book an appointment with us, that time is set aside for you - and ONLY you. Please understand that missed appointments prevent us from working with other clients.

Our Cancellation Policy

You may sometimes need to cancel your appointment with us, so we have tried to make our cancellation policy as simple as possible.

If you provide us with:

- ❖**At least 24 hours notice** – there is no charge for cancelling your appointment.

- ❖**Less than 24 hours notice** – there will be a $60 charge for the missed appointment

- ❖**Less than 3 hours notice OR you simply don't show up** – we consider this a "no-show" and you are expected to pay 100% of the fee for the missed appointment

If you do not reach us, please leave a message on our voice-mail system. Note that with Monday appointments we will need to hear from you the Friday before as the receptionists do not check voicemail on the weekend and it won't be heard until Monday at 9 am.

Note: We recognize that there are circumstances that are out of your control (sudden illness, family emergencies, etc.) and so your healthcare provider may make an exception to the above policies on those rare occasions. You will need to speak to your service provider directly for an exception.

I understand the above policy and agree to pay for missed appointments and for cancellations with less than 24 hours notice.

Signature: _____ Date: _____

_____

Signature of Parent or Guardian if client is under 19 years of age.