living wellness centre

Patient Intake Form

By filling out this comprehensive intake form, you are helping us to provide you with more effective care. We thank you for your time and patience in doing this.

PATIENT INFORMATION Date

Full Name I go by

Care Card Number (PHN)

Birthday (mm/dd/yy) Age ☐ Male ☐ Female

Home Address

City Postal Code

Primary Telephone Cellphone

Email

Would you like an email reminder for your appointments? ☐ Yes ☐ No

Occupation Work Telephone

May doctor and/or staff contact you at work? ☐ Yes ☐ No

Name of General Practitioner (MD) Telephone

Name of emergency contact

Relation to you Telephone

Where did you hear about Living Wellness Centre?

Office use only MSP ☐ Yes ☐ No ☐ CND ☐ Jane ☐ W/C ☐ GS

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Health History

NAME Date

HEALTH ISSUES

Main Concern

Other Concern(s)

Have you ever been treated by any of the following: ☐ Acupuncturist ☐ Massage Therapist ☐ Chiropractor ☐ Naturopath

Is your condition part of an ICBC or WCB claim? ☐ Yes ☐ No (If yes, please ask for additional forms.)

MEDICATIONS Please list any medications/supplements you are taking and doses.

Medications (prescription, over the counter)

Supplements (multivitamins, gingko, etc.)

LIFESTYLE

Overall stress level ☐ none ☐ low ☐ medium ☐ high

How often do you exercise? Type of exercise

Do you currently smoke? ☐ Yes ☐ No

FOR WOMEN

Are you pregnant? ☐ Yes ☐ No ☐ Maybe if yes, due date

Do you have children? ☐ Yes ☐ No If yes, by ☐ vaginal birth ☐ caesarean birth

Menstrual cycle ☐ regular ☐ irregular ☐ painful cycle

Date of your last annual Pap/Breast exam

Review of systems Please check the appropriate box for any of the following symptoms and add any comments you may feel are important.

Key: **P**=Past **N**=Now **B**=Both

P N B
General
☐☐☐ Insomnia
☐☐☐ Fatigue
☐☐☐ Weight loss
☐☐☐ Weight gain

Head
☐☐☐ Headache
☐☐☐ Dizziness
☐☐☐ Head trauma
☐☐☐ Fainting
☐☐☐ Migraines

Eyes
☐☐☐ Itching/redness
☐☐☐ Cataracts
☐☐☐ Flashes in vision
☐☐☐ Spots in vision
☐☐☐ Glaucoma

Mouth and Throat
☐☐☐ Bleeding gums
☐☐☐ Canker sores
☐☐☐ Colds sores
☐☐☐ Sore throat
☐☐☐ Jaw/TMJ problems
☐☐☐ Hoarseness
☐☐☐ Goiter

Nose
☐☐☐ Hayfever
☐☐☐ Loss of smell
☐☐☐ Nosebleeds
☐☐☐ Sinus problems

Lungs
☐☐☐ Asthma
☐☐☐ Shortness of breath
☐☐☐ Persistant cough
☐☐☐ Emphysema
☐☐☐ Bronchitis

Vascular
☐☐☐ Angina
☐☐☐ Murmurs
☐☐☐ Chest pain
☐☐☐ Palpitations
☐☐☐ Ankle swelling
☐☐☐ Cold feet/hands
☐☐☐ Leg cramps
☐☐☐ Varicose veins
☐☐☐ Low blood pressure
☐☐☐ High blood pressure

P N B
Gastro-Intestinal
☐☐☐ Bloating/gas
☐☐☐ Heartburn
☐☐☐ Ulcers
☐☐☐ Liver disease
☐☐☐ Gallstones
☐☐☐ Vomiting/nausea
☐☐☐ Abdominal pain
☐☐☐ Diarrhea
☐☐☐ Constipation
☐☐☐ Blood in stool
☐☐☐ Hemorrhoids
☐☐☐ Hernias
_____ # of bowel movements per day

Genitourinary
☐☐☐ Difficulty urinating
☐☐☐ Pain urinating
☐☐☐ Blood in urine
☐☐☐ Incontinence
☐☐☐ Bed-wetting
☐☐☐ Frequent urination
☐☐☐ Frequent infections
☐☐☐ Kidney stones

Neurological
☐☐☐ Seizures/epilepsy
☐☐☐ Strokes
☐☐☐ Tingling sensation
☐☐☐ Numbness
☐☐☐ Muscle weakness
☐☐☐ Difficulty walking
☐☐☐ Poor coordination
☐☐☐ Paralysis
☐☐☐ Speech problems
☐☐☐ Loss of memory

Muscle & Bone
☐☐☐ Joint pain
☐☐☐ Swollen joints
☐☐☐ Stiffness
☐☐☐ Muscle ache
☐☐☐ Foot trouble
☐☐☐ Bone pain
☐☐☐ Fractures
☐☐☐ Dislocations
☐☐☐ Gout

P N B
Skin
☐☐☐ Rash
☐☐☐ Itching
☐☐☐ Hives
☐☐☐ Change in moles
☐☐☐ Acne
☐☐☐ Psoriasis
☐☐☐ Eczema

Endocrine
☐☐☐ Diabetes
☐☐☐ Hypoglycemia
☐☐☐ Hormone therapy
☐☐☐ Thyroid problems
☐☐☐ Heat/cold intolerance
☐☐☐ Excessive thirst
☐☐☐ Excessive hunger
☐☐☐ Excessive sweating
☐☐☐ Night sweats

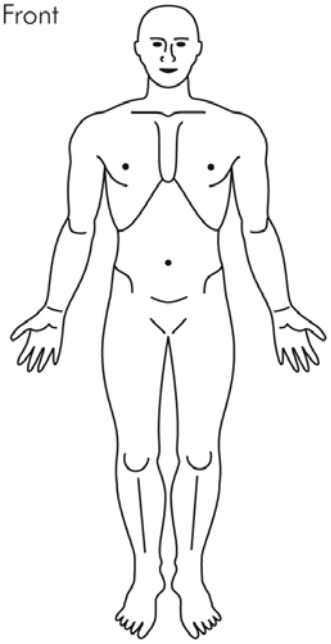
Emotional
☐☐☐ Depression
☐☐☐ Mood swings
☐☐☐ Anxiety/nervousness
☐☐☐ Tension
☐☐☐ Phobias

Conditions
☐☐☐ AIDS/HIV
☐☐☐ Eating disorders
☐☐☐ Heart disease
☐☐☐ Rheumatic fever
☐☐☐ Cancer/tumor
☐☐☐ Polio
☐☐☐ Parkinson's
☐☐☐ Multiple sclerosis
☐☐☐ Anemia
☐☐☐ Osteoporosis
☐☐☐ Osteoarthritis
☐☐☐ High cholesterol
☐☐☐ Fibromyalgia
☐☐☐ Chronic fatigue
☐☐☐ Hepatitis
☐☐☐ TIAs

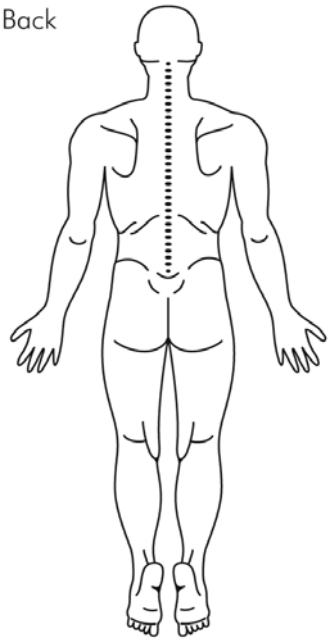
Using the following symbols, please indicate directly on the body diagrams below the area of your complaint and the type of pain experienced.

X Burning O Dull/achy
△ Sharp □ Numbness/ tingling

Front



Back



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Consent for Massage Therapy & Soft Tissue Manipulation

Please read the following carefully and enquire if you have any questions or concerns.

I hereby request and consent to the performance of massage therapy and other soft tissue procedures, including various forms of massage therapy, hydrotherapy, range of motion testing and orthopaedic testing by the Registered Massage Therapist (RMT) listed below.

I have had the opportunity to discuss the nature and purpose of massage therapy with the RMT. I understand that results are not guaranteed.

I further understand and am informed that in the practice of massage therapy, as in all health care, there are some very slight risks to treatment, including but not limited to muscle strains and tenderness, stiffness, and sometimes slights bruising. I do not expect the RMT to be able to anticipate and explain all the risks and complications associated with soft tissues manipulations.

I wish to rely on the RMT to exercise judgment during the course of my treatment(s), to apply those treatments which he/she feels at the time, based on the facts known are in my best interest.

I have read the above statements carefully and have had the opportunity to ask questions about their contents. By signing below I am signifying agreement to the above-mentioned massage therapy procedures, and I intend this consent to apply to and cover the entire course of treatment(s) for my present condition.

Signature Date

Full Name

Practitioner Signature