Vitality Clinic

Complete wellness under one roof

Patient Information

Date:

First Name: **Last Name:**

Card Care Number (PHN) **Birthday (MM/DD/YY)** **Age:**

Home Address

City **Postal Code**

Home Telephone **Cell Phone**

Email

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

Please note that we require minimum 48 hours notice for any cancellations or changes or you may incur a penalty. A fee will be charged to your account for all missed appointments. **Signature:**

Occupation **Business/Employer**

Do you have extended health insurance? ☐ Yes ☐ No

Is this treatment going to be part of an ICBC or WCB claim? ☐ Yes ☐ No. If yes, please bring all of your claim information.

May the Doctor and/or Staff contact you at work? ☐ Yes ☐ No **Work Telephone:**

Name of current General Practitioner (MD)

Date of last visit to GP: (MM/DD/YY) **Reason for last visit:**

Are you seeing a Medical Specialist? ☐ Yes ☐ No **Name of Specialist**

Reason for seeking specialist?

Emergency Contact Name: **Number:**

Relation to you:

How did you learn about Vitality Clinic?

Office use only: MSP ☐ Yes ☐ No ☐ CE ☐ W/C

Confidential Health Information

Main health complaint

Other complaints

Have you had previous care from a: ☐ Chiropractor ☐ Massage Therapist ☐ Naturopath?

If yes, name of practitioner: **Date of last visit (in the past two years):**

Have you had any recent X-rays, CT Scans or MRIs? ☐ Yes ☐ No. If yes, when:

Please list any hospitalizations, surgeries or major accidents (including MVA's) you've had and the date.

Please list any Medications or Supplements you are taking and state reasons for taking it.

Overall stress level: ☐ None ☐ Low ☐ Medium ☐ High

Reasons:

How often do you exercise: **Type of exercises:**

Do you currently smoke? ☐ Yes ☐ No. **How many per day:** **How long have you smoked?**

What would you like to gain from today's visit? What are the two most important health goals?

For Women

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

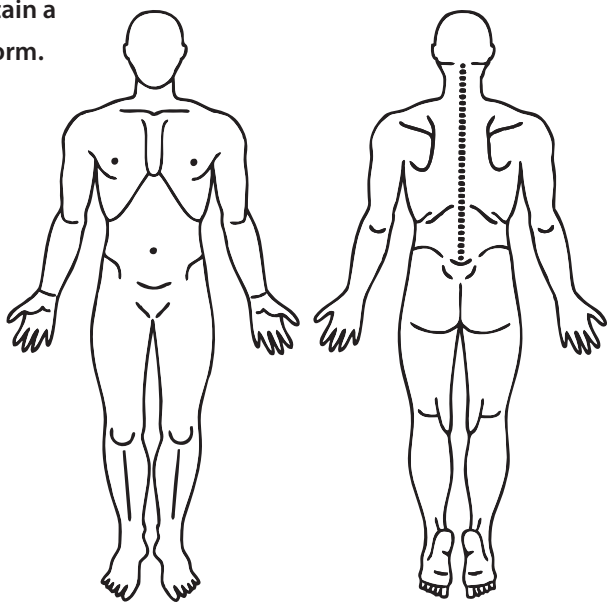
Do you have children? ☐ Yes ☐ No. If yes, by: ☐ natural ☐ caesarean delivery

Menstrual cycle: ☐ regular ☐ irregular ☐ cramps ☐ painful cycle

Date of your last breast exam:

Review of Systems

Pain and discomfort can be traced back to many different origins. To obtain a complete picture of your overall health, please complete the following form. If you are having any difficulty with the following, please check the box:



General
- ☐ Insomnia
- ☐ Fatigue
- ☐ Weight Loss
- ☐ Weight Gain

Head
- ☐ Headache
- ☐ Dizziness
- ☐ Head Trauma
- ☐ Fainting
- ☐ Blacking out

Eyes
- ☐ Itching/redness
- ☐ Change in vision
- ☐ Cataracts
- ☐ Light sensitivity
- ☐ Flashes in vision
- ☐ Spots in vision
- ☐ Glaucoma

Ears
- ☐ Ringing/ tinnitus
- ☐ Impaired Hearing
- ☐ Earache
- ☐ Dizziness
- ☐ Discharge

Mouth and Throat
- ☐ Bleeding gums
- ☐ Cold sores
- ☐ Sore throat
- ☐ Jaw/TMJ problems
- ☐ Hoarseness
- ☐ Swollen glands
- ☐ Goiter

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

Lungs
- ☐ Difficulty breathing
- ☐ Shortness of breathing
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Asthma
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Infections

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

Gastro-intestinal
- ☐ Bloating/gas
- ☐ Heartburn
- ☐ Ulcers
- ☐ Liver disease
- ☐ Gall bladder disease
- ☐ Vomiting/nausea
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Hemorrhoids
- ☐ Hernias

Urinary
- ☐ Difficulty urinating
- ☐ Pain urinating
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Bed-wetting
- ☐ Urinary urgency
- ☐ 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
- ☐ Arthritis
- ☐ Bone pain
- ☐ Fractures
- ☐ Disclocations

Skin
- ☐ Rash
- ☐ Itching/hives
- ☐ Changes 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
- ☐ Alcohol/drug abuse

Conditions
- ☐ AIDS/HIV
- ☐ Eating disorders
- ☐ Heart condition
- ☐ Rheumatic arthritis
- ☐ Rheumatic fever
- ☐ Alcoholism
- ☐ Cancer/tumor
- ☐ Polio
- ☐ Parkinson's
- ☐ Multiple sclerosis
- ☐ Gout
- ☐ Anemia
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ High cholesterol
- ☐ Fibromyalgia
- ☐ Chronic fatigue
- ☐ Hepatitis
- ☐ Migraines

Registered Massage Therapy Consent Form

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 orthopedic 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 tenderness, stiffness, and sometimes slight 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 judgement 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.

I authorize any information I have provided to be shared with any practitioner working within Vitality Clinic.

Signature of patient **Date (DD/MM/YY)**

Full name (please print)

Signature of Therapist **Date (DD/MM/YY)**

Full name (please print)