BALANCE
INTEGRATED HEALTHCARE

# Health History

Date of initial Health Tx:

Update 1 _____
2 _____
3 _____
4 _____
5 _____
6 _____

An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future, please let us know. All information gathered for treatments is confidential except as required or allowed by law to facilitate diagnosis (assessment) or treatment.

Name: _____ Date of Birth: _____ Gender: _____

Address: _____
Number Street Suite City Province Postal Code

Occupation: _____ E-mail: _____

Tel (home): _____ Tel (work): _____ Cell: _____

Physician's Name: _____ Tel: _____

Physician's Address: _____
Number Street Suite City Province Postal Code

In Emergency Notify: _____ Relationship: _____

Tel: _____ How did you hear about us? _____

General Health Status: _____

What is your primary complaint? _____

How long have you had this condition? _____

Have you experienced this or a similar condition in the past? ☐ No ☐ Yes When? _____

What aggravates it? _____ What relieves it? _____

Is the condition getting progressively worse? ☐ No ☐ Yes ☐ Constant ☐ Comes & Goes

Have you been given a diagnosis for this problem? Please describe: _____

List all medications you are taking and corresponding conditions.
(including prescription drugs, vitamins/minerals, herbal supplements, recreational drugs, birth control pill, etc.)

_____

List nature of surgeries and injuries with dates: (include auto accidents and work-related injuries)

_____

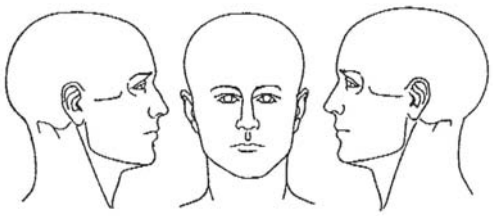
_____

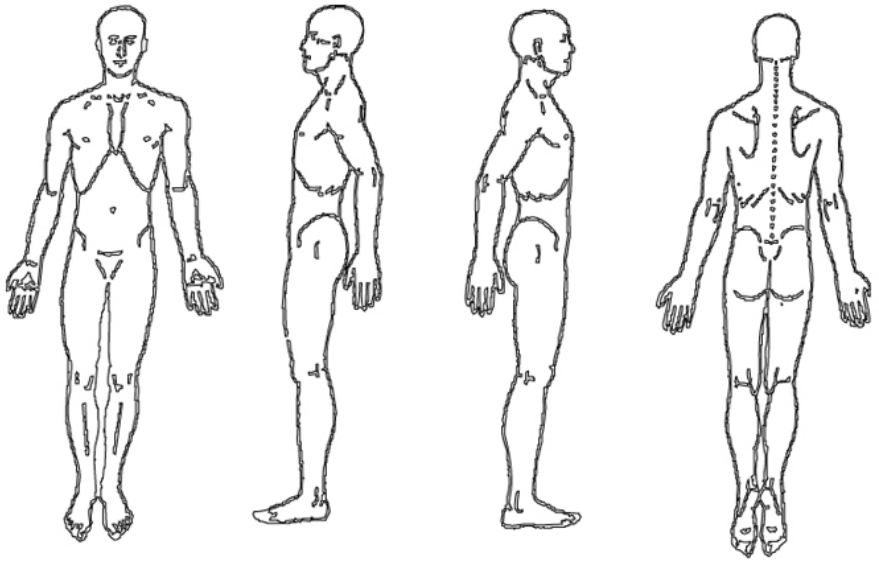
Present involvement in other healthcare? ☐ Yes ☐ No Please describe: _____

Were you referred by a Healthcare Worker? ☐ Yes ☐ No Please describe: _____

History of Massage Therapy: _____

## Please shade all areas of pain and/or discomfort





**Pain Scale/Disability**

1 2 3 4 5 6 7 8 9 10

Character

Frequency/Duration

Aggravating Factors

Relieving Factors

Radiation

Associated Symptoms

## Please check all items that apply

**Musculoskeletal Pain & Discomfort**

- ☐ Neck
- ☐ Back
- ☐ Knee / Leg
- ☐ Shoulder / Arm
- ☐ Hand / Wrist
- ☐ Foot / Ankle
- ☐ Scoliosis
- ☐ Bursitis
- ☐ Tendonitis
- ☐ Sciatic
- ☐ Arthritis
  - Type _____
- ☐ TMJ
- ☐ Degenerating disc
- ☐ Osteoporosis
- ☐ Edema / Swelling
- ☐ Fibromyalgia
- ☐ Chronic fatigue
- ☐ Other _____

**Head / Eyes / Ears / Nose / Throat**

- ☐ Headaches
  - Past or Present
  - Duration _____
  - Tension / Cluster _____
- ☐ Migraines
- ☐ Dizziness / Vision problems
- ☐ Ear problems
- ☐ Other _____

**Skin / Hair**

- ☐ Itching / Rashes
- ☐ Eczema / Psoriasis
- ☐ Plantar warts
- ☐ Sensitive skin / Bruise easily
- ☐ Dry Skin / Scalp
- ☐ Other _____

**Cardiovascular**

- ☐ Pacemaker
- ☐ High or low blood pressure
- ☐ Heart attack
- ☐ Stroke / CVA
- ☐ Varicose / Spider veins
- ☐ Fainting
- ☐ Hemophilia

**Resipiratory**

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Asthma / Wheezing

**Digestive**

- ☐ Ulcers
- ☐ Constipation
- ☐ Crohn's / Colitis
- ☐ Kidney / Bladder
- ☐ Liver / Gallbladder

**Gynecological**

- ☐ PMS
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Light / Heavy periods
- ☐ Fibroids
- ☐ Endometriosis
- ☐ Infertility
- ☐ Currently pregnant
  - How many months? _____
- ☐ Menopause or other
  _____

**Other**

- ☐ Loss of sensation
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Allergies _____
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Tuberculosis
- ☐ AIDS / HIV
- ☐ Hepatitis
- ☐ Surgical implants
- ☐ Pins / Wires / Plates / Prostheses
- ☐ High / Low stress level
- ☐ Regular exercise program
- ☐ Sensitivities _____
- ☐ Infectious Diseases _____

BALANCE
INTEGRATED HEALTHCARE™

# Consent Information

We would like your consent. We want you to understand the services we hope to provide to you, the cost involved, and what we do with personal information we obtain from you. If you have any questions regarding any of the following information, please do not hesitate to ask.

**Consent for Treatment**
I have read and understand all of the associated forms, answered them truthfully and to the best of my knowledge, and fully consent to treatment at Balance Integrated Healthcare™. I understand that there is a 24-hour cancellation policy and if I fail to notify the clinic, I may be charged for my session. I also understand that the healthcare practitioners working at Balance Integrated Healthcare™ are independent contractors and I will address any concerns about my treatment directly with my therapist.

**Consent for the Cost of Our Services**
I understand that I am being charged by Balance Integrated Healthcare™ for time with a therapist, which may include, but is not limited to: assessment; treatment; lifestyle counselling; and homecare prescription.

**Consent for Personal Information**
I understand that in order to provide me with the services I am seeking, Balance Integrated Healthcare™ will collect some personal information about me (ie. telephone number, address, emergency contact information).

I have reviewed Balance Integrated Healthcare's™ privacy policy about the collection, use and disclosure of personal information, the steps taken to protect the information and my right to review my personal information. I understand how the privacy policy applies to me. I have been given the chance to ask any questions about the privacy policy, and they have been answered to my satisfaction.

I understand that, as explained in Balanced Integrated Healthcare's™ Privacy Policy, there are some rare exceptions to these commitments.

**Consent for Receiving Information**
I understand that if I do not check off the following boxes I will receive the following:

*Yes* ☐ *No* ☐ Please send me the monthly Balance Integrated Healthcare™ Healthy Insights newsletter (find out about a new health topic every month) written by one of the practitioners at Balance Integrated Healthcare™. *(email required on health history form)*

*Yes* ☐ *No* ☐ I would like to receive email/mail notices of promotions and special offers from Balance Integrated Healthcare™ (helps you stay on top of all the events at Balance Integrated Healthcare™ including upcoming seminars/workshops and newly acquired services)

I hereby agree to Balance Integrated Healthcare™ collecting, using and disclosing my personal information only with my expressed written authorization.

Signature | Name (please print) | Date

Notes (office use only)