Core Link Wellness Centre

2238 Caroline Street, Burlington, ON L7R 1M6

STANDARD PATIENT INFORMATION FORM

Date: _____

Name: _____ Date of Birth: mm/dd/yy _____/_____/_____

Address: _____City: _____ Postal code:_____

Phone #: (Business) _____ (Home) _____ (Cell) _____

Email: _____(Check this if you don't want to receive our monthly e-newsletter)

Preferred contact: Business #____ Cell#____ Home#____ Email____

Occupation: _____ Referred by: _____

HEALTH HISTORY (Please list both past and present information)

Doctor: _____ Phone #:_____ Address: _____
Current Medications (conditions they treat): _____
_____
Surgeries (Please list and date): _____
_____
Please list the presence and location of any internal pins, wires, artificial joints of special equipment: _____
_____
Chiropractor: _____ Phone #: _____
List other current therapies (i.e. physiotherapy): _____
Motor Vehicle Accident? YES NO Date: _____
Other Accident(s)? _____ Date(s): _____
Reason for treatment: _____
Have you ever received a professional massage? YES NO

Please check off all applicable boxes below (past and current):

Cardiovascular
- o High blood pressure
- o Low blood pressure
- o Chronic congestive heart failure
- o Heart disease
- o Myocardial infarction
- o Phlebitis
- o Cardio-vascular accident
- o Stroke
- o Pacemaker
- o Varicose veins
- o Blood clots
- o Osteoarthritis
- o Lymph edema
- o Other

Infectious Diseases
- o Hepatitis
- o Tuberculosis
- o HIV
- o Other

Musculo-skeletal
- o Bone or joint disease
- o Tendonitis
- o Bursitis
- o Fractures
- o Osteoarthritis
- o Rheumatoid arthritis
- o Sprains/strains
- o Swelling
- o Stiffness
- o Spasms/cramps
- o Pain (check area)

__Jaw __Neck __Shoulder __Elbow __Wrist __Hip __Knee __Ankle __Back

Digestive
- o Constipation
- o Gas/bloating
- o Nausea/vomiting
- o Irritable bowel syndrome
- o Liver/gall bladder
- o Kidney/bladder
- o Other

Skin
- o Allergies (anaphylactic)
- o Rashes
- o Athletes foot
- o Warts
- o Cold sores
- o Eczema/psoriasis
- o Other (contagious)

Respiratory
- o Chronic cough
- o Bronchitis
- o Shortness of breath
- o Asthma
- o Emphysema
- o Smoking
- o Other

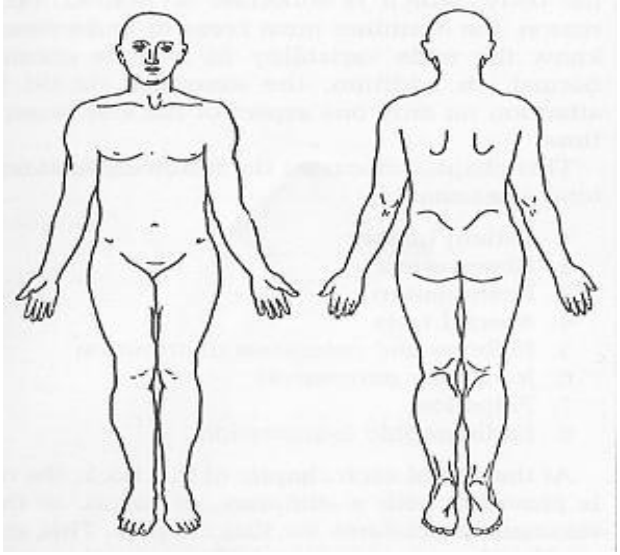
Reproductive
- o Pregnancy (trimester __)
- o PMS
- o Other

Nervous System
- o Herpes/shingles
- o Numbness/tingling
- o Chronic pain
- o Fatigue
- o Sleep disorder
- o Loss of sensation
- o Other

Other
- o Drug/alcohol addiction
- o Nicotine/caffeine addiction
- o Diabetes
- o Vision/hearing loss
- o Headaches/migraines
- o Cancer
- o Epilepsy
- o Allergies (please list)

Please Turn Over →

INDICATE AREAS OF PAIN OR DISCOMFORT



CLIENT CONSENT STATEMENT

In keeping with the Health Care Consent Act (1996), it is my choice to receive therapy. I understand that an assessment by a therapist is required to determine the best course of treatment. I agree to communicate with my therapist at any time if I have any questions, if I feel uncomfortable, or I feel that my well being is being compromised. I will consent to the therapist working only on those areas of my body that I am comfortable with. I am aware that I may remove only the clothing with which I am comfortable and may terminate the treatment at any time at my discretion. I understand and am aware of the posted fees and cancellation policy. I am also aware of the possible side effects from a treatment such as temporary muscular discomfort (24-48hrs post treatment), possible dizziness. I understand the therapist will recommend remedial exercises and home care. I am aware that the clinic is not responsible for any lost, stolen or damaged articles.

I understand that any personal information collected will be used in a responsible manner; and only to the extent that it is necessary for the services provided by Core Link Wellness Centre. I give permission for the professionals, therapists, doctors, practitioners and receptionists under the guidance of Steve Nagy, Director of the clinic to have access and use of my personal information. I am aware that all information provided is private and confidential and will not be released without my written consent. A copy of the clinic's full Privacy Policy may be requested at any time.

FEE SCHEDULE Prices do not include HST

Massage Therapy 90 minutes	$110.62	Naturopath First Consult	$165.00
Massage Therapy 60 minutes	$79.65	Naturopath Second Consult	$95.00
Massage Therapy 45 minutes	$61.95	Naturopath Standard Follow up	$85.00
Massage Therapy 30 minutes	$48.67	Acupuncture	$70.00
Osteopathic Techniques 1 hr	$100.00	Reflex Therapy	$79.65
Osteopathic Techniques 1\2 hr	$60.0	Reiki	$80.00

Signature (18 years of age or older):_____**Date:**_____

Parental/Guardian Signature:_____**Date:**_____

CANCELLATION POLICY

Missed appointments and those cancelled without the required 24 hours notice will be subject to the <u>full cost</u> of the appointment.

Date of Initial Health History:_____
Update 1: _____
Update 2: _____
Update 3: _____
Update 4: _____
Update 5: _____