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| Core Link Wellness Centre | 2238 Caroline Street, Burlington, ON L7R 1M6 |

## STANDARD PATIENT INFORMATION FORM FOR OSTEOPATHIC TREATMENT

##

## 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**

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

**Infectious Diseases**

* Hepatitis
* Tuberculosis
* HIV
* Other
* Other

**Musculo-skeletal**

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

\_\_Jaw \_\_Neck \_\_Shoulder

\_\_Elbow \_\_Wrist \_\_Hip

\_\_Knee \_\_Ankle \_\_Back

**Digestive**

* Constipation
* Gas/bloating
* Nausea/vomiting
* Irritable bowel syndrome
* Liver/gall bladder
* Kidney/bladder

**Skin**

* Allergies (anaphylactic)
* Rashes
* Athletes foot
* Warts
* Cold sores
* Eczema/psoriasis
* Other (contagious)

**Respiratory**

* Chronic cough
* Bronchitis
* Shortness of breath
* Asthma
* Emphysema
* Smoking
* Other

**Reproductive**

* Pregnancy (trimester \_\_)
* PMS
* Other

**Nervous System**

* Herpes/shingles
* Numbness/tingling
* Chronic pain
* Fatigue
* Sleep disorder
* Loss of sensation
* Other

**Other**

* Drug/alcohol addiction
* Nicotine/caffeine addiction
* Diabetes
* Vision/hearing loss
* Headaches/migraines
* Cancer
* Epilepsy
* 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

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| --- | --- | --- | --- | --- |
| Massage Therapy 90 minutes Massage Therapy 60 minutesMassage Therapy 45 minutesMassage Therapy 30 minutesOsteopathic Techniques 1 hrOsteopathic Techniques 1\2 hrAthletic Therapy Initial Assessment |  $110.62$79.65$61.95$48.67 $110.00$60.00$75.00 |  | Naturopath First ConsultNaturopath Cancer 1St Consult Naturopath Second ConsultNaturopath Standard Follow upAcupunctureReflex TherapyAthletic Therapy ½ hr | $165.00 $210.00$95.00$85.00$70.00$79.65 $50.00 |

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

**Parental/Guardian Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Initial

Health History:\_\_\_\_\_\_\_\_\_

Update 1: \_\_\_\_\_\_\_\_\_\_\_\_\_

Update 2: \_\_\_\_\_\_\_\_\_\_\_\_\_

Update 3: \_\_\_\_\_\_\_\_\_\_\_\_\_

Update 4: \_\_\_\_\_\_\_\_\_\_\_\_\_

Update 5: \_\_\_\_\_\_\_\_\_\_\_\_\_

 **CANCELLATION POLICY**

**Missed appointments and those cancelled without the required**

**24 hours notice will be subject to the full cost of the appointment.**