Brantford Integrative Health Centre

Osteopathy | Naturopathy | Accupuncture | Counselling

Jennifer Perry, RMT
PATIENT INTAKE SHEET 2015/16

Patient Name: _____
Last First Middle

D.O.B.: _____ **Sex:** ☐ M ☐ F
Year Month Day

Address: _____
Street Address

_____
City

_____
Postal Code

Phone :

_____
Residence

_____
Work

_____
Cell

May we leave a detailed message?

Yes [ ] No [ ]

Yes [ ] No [ ]

Yes [ ] No [ ]

Email: _____

Emergency Contact Name_____**Emergency Contact Telephone Number**_____

Date of first Assessment: _____ / **Previous Patient [ ]**
(Day) (Month) (Year)

Please note: Cancellation of an appointment requires 24 hours notice. As of Jan 1, 2015 a $75 cash deposit or a Visa/MC/AMEX number will be kept on file and used if you fail to attend a scheduled appointment without 24 Hours notice.

_____ _____ _____ _____ **Exp Date:** _____

[ ] Visa, [ ] Master Card [ ] American Express [ ] Cash [ ] Cheque

($75 cash refunds will be returned on your last appointment, all other documents with your credit card information will be shredded)

By signing this form, you acknowledge and accept responsibility for payment of missed appointments.

_____
Signature of Patient

_____
Signature of Parent or Legal Guardian

Date: _____

94 Charing Cross Street Brantford ON N3R 2H6
Phone 519-304-7044 Fax 519-304-4635 bich2014@rogers.co

Case History Form

Date: _____ Name: _____

Address: _____ (Postal Code)

Telephone: (Home) _____ (Business) _____

Occupation: _____ Date of Birth: _____

Family Doctor: _____ Address: _____

Is this your first massage ? Yes / No

Where did you hear about this clinic ? _____

Health History

Allergies _____ (Plants, food, nuts, fragrances)

Head and Neck
Headaches (type)..... 0
Vision problems..... 0
Sinus problems..... 0
Contact lenses..... 0
Earaches..... 0

Respiratory
Emphysema / Bronchitis..... 0
Shortness of breath..... 0
Chronic cough..... 0
Asthma..... 0

Cardiovascular
Myocardial Infarction (Heart Attack)..... 0
Congestive Heart Failure..... 0
High blood pressure..... 0
Low blood pressure..... 0
Poor circulation..... 0
Varicose veins..... 0
Phlebitis..... 0
Stroke..... 0

Skin
Skin Condition (Inflammatory / Type)..... 0
Loss of sensation..... 0
Bruise easily..... 0

Other Conditions
Internal Pins / Wires / Artificial Joints or Special Equipment..... 0
Arthritis (type / areas affected)..... 0
Gastrointestinal problems..... 0
Diabetes (type / onset)..... 0
Liver / Gallbladder..... 0
Kidney problems..... 0
Hemophilia..... 0
Epilepsy..... 0
TB / HIV..... 0
Cancer..... 0
Other _____ 0

Women
Caesarian / Gynecological surgery..... 0
Menstrual / Menopausal problems..... 0
Pregnancy (previous / current)..... 0

Muscles/Joints (P = Pain S = Stiffness T = Tension)
(circle appropriate letter)
Neck..... P / S / T
Shoulders..... P / S / T
Arms / Hands (left / right)..... P / S / T
Back (upper - middle - lower)..... P / S / T
Hips..... P / S / T
Legs (left / right)..... P / S / T
Other _____ P / S / T

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Exercise / Sport: _____ Frequency: _____

Eating Habits: _____ Sleeping Difficulties: _____

Do you drink Coffee / Tea ? (Yes / No) per Day?: _____ Do you Smoke ? (Yes / No) per Day?: _____

Do you have problems with: Stress..... 0 Fatigue..... 0 Grief..... 0
Pain..... 0 Anxiety..... 0 Depression..... 0

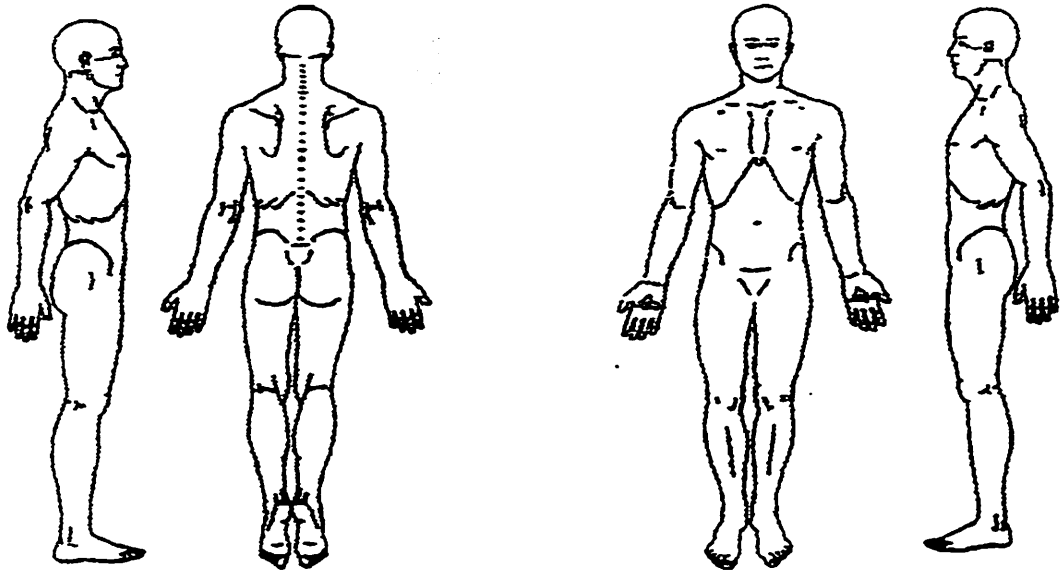
Injuries / Surgery (Type / Approx. Date) Current Medication (Name / For what condition)

Other Health Care
Chiropractor.....(
Physiotherapy.....(
Acupuncture.....(
Psychotherapy.....(
Reflexology.....(

Please specify any other symptoms or medical information that you feel would be relevant:

Please indicate any areas in which you presently experience discomfort by shading on the figures below:

(RMT)
(Codes)
(60/65)
( )



I _____, of my own free will consent to be treated for the above stated areas of concern

I understand that the health information that I give on this form will be confidential and will be used for no purpose other than the professional therapist's clinical records. Address information on this form may be used to inform the client of any clinic changes. (IE: new therapists, new prices, new hours)

Alternative courses of treatment, where applicable and relevant, will be explained to me, as well as the possible risks and side effects of the proposed treatment plan.

I understand that I may stop or modify the treatment at any time before or during the treatment.

I certify that the information given in this form is true and accurately reflects my past and present health status.

I understand that cancellation of an appointment requires twenty-four hours' notice. Failure to do so may result in cancellation fee equal to the cost of the treatment being charged.

Print Name _____ Signature _____ Date _____