Perfect Balance
Wellness Centre

519.804.1697 • 125 Bedford Road, Kitchener, ON N2G 3A3

HEALTH HISTORY
PATIENT INFORMATION

Patient Information (please print clearly) _____

Name: _____ Date of Birth: (mm/dd/yyyy) ____/____/_____ Age: _____

Address: _____ City: _____ Postal Code: _____

Phone: (H) _____ (B) _____ (M) _____

Email: _____

Occupation: _____ Where did you find our number? _____

If online, what site referred you? _____

Health History

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: _____

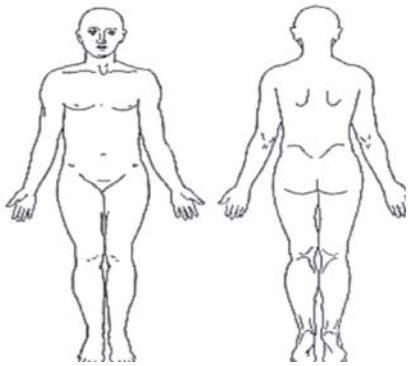
List other current therapies (ie: physiotherapy): _____

Motor Vehicle Accident? ❑ Yes ❑ No Date: _____

Other Accident(s)?: _____

Date(s): _____

Indicate Areas of Pain or Discomfort



Notes: _____

please turn over...

Please Check All Applicable Boxes

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
- ❑ Lymphedema
- ❑ Other

Infectious Diseases

- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ HIV
- ❑ 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
- ❑ Other _____

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
- ❑ Cancer
- ❑ Epilepsy
- ❑ Headaches/migraines
  How often: _____
- ❑ Allergies
  __Food __Drug
  __Environmental

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 am aware that all information provided is private and confidential and will not be released without my written consent. 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) and 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.

Cancellation Policy

We require 24 hours notice if you are unable to make your scheduled appointment.
After an one initial warning all subsequent missed appointments will then be billed at the regular fee.

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

Parental/Guardian Signature:_____ Date:_____