Complete Balance Health Centre
2896 Bloor Street West
Toronto, ON, M8X 1B5
(416) 769-1163

Today's Date: _____

First Name				**Last Name**			
Address				**City**		**Postal Code**	
DOB				**Occupation**			
H Telephone		**Cell**			**W Telephone**		
Email							

Physician: _____ Address: _____ Phone: _____
Employer: _____
How did you hear about us? ☐Friend ☐Internet ☐Signage Other: _____
Name of Guardian if Applicable: _____
Emergency Contact: _____ Relation: _____ Phone: _____

Do you have a family history of:

Cancer	**YES**	**NO**	Heart disease/stroke	**YES**	**NO**
Diabetes	**YES**	**NO**	Allergies	**YES**	**NO**
			Other(s)_____		

Lifestyle:
Special Interest:_____ Sports:_____
Hobbies:_____ Health Goal: _____
Number of Hours per Week: _____

☐Coffee	☐No ☐Yes	_____ cups/day
☐Tea	☐No ☐Yes	_____ cups/day
☐Cigarettes	☐No ☐Yes	_____ x/day
☐Alcohol	☐No ☐Yes	_____ x/week
☐Exercise	☐No ☐Yes	_____ x/week

What type of exercise:_____
_____
Vitamins/ Herbal Supplements? ☐No ☐Yes
What type and dosage:_____
_____

Mental health:
☐stress
☐depression
☐bipolar
☐others: _____

What level of care are you interested in pursuing?
☐symptom relief only
☐preventative and maintenance care

Have you received the following services before?
☐massage therapy
☐naturopathy
☐foot care
☐ psychotherapy
☐ physiotherapy
☐ orthotics

Please indicate by circling any of the following conditions that are causing you a problem.
Please check any conditions that have given you problems in the past.

GENERAL SYMPTOMS
Headache
Fever
Chills
Sweats
Fainting
Dizziness
Convulsions
Loss of sleep
Fatigue
Nervousness
Loss of weight
Numbness or pain in legs, hands, arms
Allergies
Wheezing
Neuralgia

E.E.N.T
Failing vision
Near sightedness
Far sightedness
Crossed eyes
Eye pain
Deafness
Earache

E.E.N.T Cont'd
Ear discharge
Nose bleeds
Nasal obstruction
Hoarseness
Sore throat
Hay fever
Asthma
Dental decay
Gum trouble
Frequent colds
Enlarged thyroid
Tonsillitis
Sinus infection
Nasal drainage
Enlarged glands

SKIN:
Skin eruptions
Itching
Bruises easily
Dryness
Boils
Varicose veins
Sensitive skin
Hives of allergy

RESPIRATORY:
Chronic cough
Spitting up blood
Spitting up phlegm
Chest pain
Difficulty breathing

CARDIOVASCULAR:
rapid beating heart
slow beating heart
High blood pressure
Low blood pressure
Previous heart stroke
Hardening of arteries
Swelling of ankles
Poor circulation
Paralytic stroke

MUSCLE & JOINT:
Stiff neck
Back ache
Neck pain
Swollen joints
Painful tailbone
Foot trouble
Pain in shoulders

M & J Cont'd:
Hernia
Spinal curvature
Faulty posture
Arthritis

GENITOURINARY:
Frequent urination
Painful urination
Blood in urine
Pus in urine
Kidney infection
Kidney stones
Bed wetting
Inability to control urine
Prostate trouble

GASTROINTESTINAL:
Poor appetite
Difficult digestion
Excessive hunger
Belching or gas
Nausea
Vomiting
Vomiting of blood
Colon trouble

GASTRO Cont'd:
Constipation
Intestinal wounds
Liver trouble
Gall bladder trouble
Jaundice
Colitis
Pain over stomach
Hemorrhoids (Piles)
Bowel Movement:
How often: _____

FOR WOMEN ONLY:
Painful menstruation
Irregular cycle
Cramps or backache
Previous miscarriage
Congested breast
Lumps in breast
Menopausal symptoms
Excessive flow
Hot flashes
# of pregnancies____
# of abortions_____
# of miscarriages____

Currently pregnant? Y / N

HAVE YOUR EVER HAD ANY OF THE FOLLOWING DISEASES? IF SO, PLEASE INDICATE:

Aneurysm	High blood pressure	Hepatitis	Polio	Sleeping difficulty
Cancer	Heart condition	Fatigue	HIV	Psoriasis
Respiratory conditions	Diabetes	Arthritis	Osteoporosis	Pneumonia

Consent for Treatment

I acknowledge that my therapist has provided me with such information that is pertinent to the treatment of my condition(s).

Alternative courses of treatment have been explained as well as possible risks and side effects of my therapist's proposed treatment plan.

I understand full the consequences of having treatment or not having treatment. I understand that my therapist uses touch and mobilization. I consent to the Practitioner to holding and moving my body to facilitate the treatment.

I appreciate that my consent herein provided may be revoked at any future time I so choose.

I provide my full voluntary informed consent to be treated.

Client Name: _____ Signature: _____ Date:_____