Complete Balance Health Centre
2862 Lakeshore Blvd West, 2nd floor
Toronto, ON, M8V 1H9
(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: _____ **Hours per week** _____
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 ca

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. O = current √ = 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

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What is your chief complaint? (please also indicate in the diagram below): _____

Have you been treated for your current condition before: Yes/No. If Yes, please explain_____

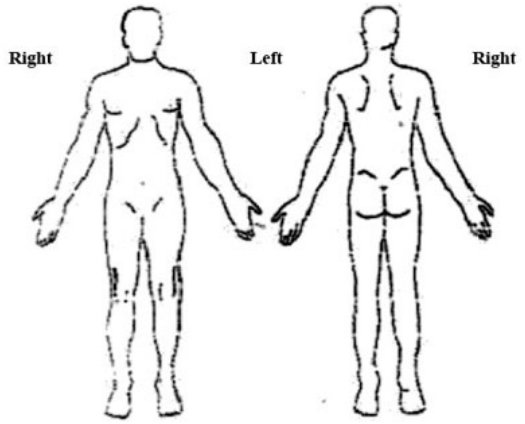
Are you presently taking any medication? Yes / No. If yes please list them: _____

Height: _____ Weight: _____

Pain Diagram

Indicate all areas of

////// Stiffness
●●●● Numbness
0000 Pins & Needles
✕✕✕ Burning
****** Aching**
††† Stabbing



Patient Questionnaire

Accidents / Falls / Fractures / Dislocations _____

Other medical conditions? _____

Any surgeries? When? _____

CONSENT TO MASSAGE THERAPY TREATMENT

I have received information about the proposed physical assessment and have been informed about the nature of the massage therapy treatment. I have been informed and understand the benefits, risks, side effects, contraindications (if present), alternative courses of treatment and consequences of not having the treatment. I understand that it is my right to stop or modify the treatment at any given time and that the massage therapist expects my input regarding the comfort of pressure throughout the treatment. The therapist has given me instruction on dressing/undressing procedures as well as instruction on positioning and covering during the treatment, hydrotherapy applications, and remedial exercise programs. I am fully aware of the cost of the treatment and duration of both the treatment and assessment.

Massage Treatment	Cost	Massage Treatment	Cost
30 minutes	$70.00 + HST	90 minutes	$150.00 + HST
45 minutes	$90.00 + HST	120 minutes	$215.00 + HST
60 minutes	$110.00 +HST		

All information in my file will be kept confidential, although the file will be shared among the treating therapists in this facility. The sharing of the file will improve the flow of information among the professionals to ensure the utmost quality of care.

I understand that written authorization will be obtained prior to the release of any information, except when required by a court of law.

I understand that my treatment may change from time to time, and necessary functional ability testing may be performed at my health professional discretion. I also understand that results are not guaranteed.

I have read the above consent and have had the opportunity to ask questions regarding its content. By signing below, I agree to the proposed physical testing and massage therapy protocol presented by the registered massage therapist. I intend this consent to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

Please note:

- Time of treatment includes assessment and dressing/undressing.
- Please be on-time for your appointment. If you are late, the time of your treatment may be decreased but you will be charged in full for the scheduled appointment.
- If you need to cancel your appointment, please give us 48 hour notice. Otherwise you may be charged for the missed appointment

_____ _____

RMT Name (please print) Client/Guardian (please print)

_____ _____ _____

RMT Signature Client Signature Date