AHI - New Patient Information

Personal Information

Last Name	**First Name**	**Middle Initial**
Address: Street		**Unit #**
City	**Province**	**Postal Code**
Date of Birth (Day/Month/Year)		
Home Phone #	**Work Phone #**	**Cell Phone #**
May the clinic leave you messages relating to your visits? □**YES** □ **No**		
Email		
Employer		**Occupation**
Emergency Contact Name and Relationship		**Phone #**

How did you hear about the clinic? _____

Which members of the clinic will you be seeing?

□ **Chiropractor** □ **Physiotherapist** □ **Massage Therapist** □ **Naturopath** □**Personal Trainer**

Family Doctor
Name _____
Phone # _____
Fax # _____

Specialist
Name _____
Phone # _____
Fax # _____

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Health Information

What are your health concerns and/or reasons for coming to the clinic, in order or importance?

1. _____
2. _____
3. _____

Are you currently receiving treatment from another health care professional? If so, for what?

_____

Do you have any internal pins, wires, artificial joints or special equipment? If so, please list what and where?

_____

What is the reason for seeking massage therapy? _____

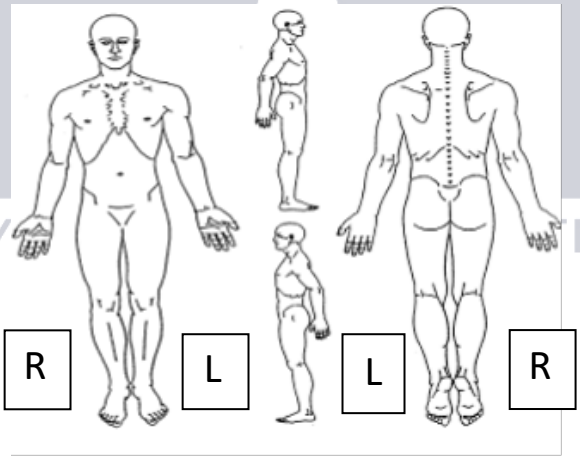
Current medications and for what conditions? _____

Is this visit a result of an injury? Date? _____

Have you had any surgeries in the past? Date? _____

Instructions: *Mark these drawings according to where you feel your pain, by referring to the key below.*

Sharp /////	Burning XXXXX	Pins & Needles OOOOO	Aching +++++
Stabbing VVVVV	Numbness -----	Dull *****	Other vvvvv



Please circle your current pain level

no pain 0 1 2 3 4 5 6 7 8 9 10 **worst pain imaginable**

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Physical history (Place an "X" beside any condition you have had or presently have)

Musculoskeletal		**Nervous System**		**Cardio-Vascular-Resp.**	
Neck problems		Numbness		Chest pain	
Upper back problems		Loss of feeling		High/Low blood pressure	
Shoulder problems		Headaches		Difficulty breathing	
Low back problems		Dizziness		Persistent Cough	
Elbow problems		Fainting		Coughing phlegm/blood	
Knee problems		Confusion		Lung problems	
Ankle/foot problems		Depression		Diabetes	
Arthritis		Concussion		Asthma	
Other Conditions not listed:		Anxiety		Varicose veins	
		Loss of balance		Hypoglycemia	
Allergies/sensitivities:		Paralysis		Angina	
		Seizures		Murmur/palpitations	
		Forgetfulness		Hemophilia	
Gastrointestinal/Endocrine		**Genito-Urinary System**		**Ears/Nose/Eyes/Throat**	
Poor appetite		Painful urination		Vision problem	
Excessive hunger/thirst		Excessive urine		Ear ringing	
Heat/cold intolerance		Discoloured urine		Ear infections	
Nausea/vomiting		Urgency to urinate		Hearing loss	
Bloody/black stool		Recurring infections		Voice changes	
Weight loss/gain		Kidney stones		Gum/teeth/jaw problem	
Ulcer		Sexually transmitted infections		Nasal discharge	
Thyroid problems		HIV		Nose bleeds	
Liver/Gall bladder problem		Hepatitis		Sinus problems	
Female		**Male**		**Skin**	
PMS		Testicular pain		Moles	
Irregular cycle		Itching		Rashes	
Irregular bleeding/discharge		Sores		Acne	
Pregnancy		Irregular discharge/bleeding		Dryness	
Sores		Hernia		Itchiness	
Sexual concerns		Sexual concerns		Psoriasis	
Breast lumps/pain/tenderness/discharge		Chest lumps/pain/tenderness/discharge		Eczema	
Hernia				Infectious skin conditions	

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Consent for Massage Therapy Service and Fee's

I have requested assessment and treatment by a Registered Massage Therapist (RMT) at The Active Health Institute. As part of my therapeutic assessment and treatment, I am aware that in certain circumstances the Registered Massage Therapist may need to assess and touch sensitive area(s) of my body which may include the following; *please initial beside each below:*

____Lower back ___Chest Wall Muscles ___Upper and Inner Thigh(s) ___Buttocks (gluteal muscles) ___Breast (s)

The RMT has explained the following to me and I fully understand the proposed assessment and treatment including (please initial):

_____The nature of the assessment, including the clinical reason(s) for assessment of the above area(s) and the draping methods to be used

_____The expected benefits of the assessment

_____The potential risks of the assessment

_____The potential side effects of the assessment

_____That consent is voluntary

_____That I can withdraw or alter my consent at any time. I voluntarily give my informed consent for the assessment as discussed and outlined above.

Patient Name (print): _____

Patient Signature: _____ **Date:** _____

RMT Signature: _____

Massage Therapy Cost/Session

30min	$70.00
45min	$85.00
60min	$105.00
90min	$140.00
120min	$210.00
Complex (60min)	$125.00
Acupuncture	$80.00
Acupuncture Initial Assessment	$110.00

Cancellation Policy

Your appointment time has been reserved especially for you. If you are unable to keep this reservation, please provide us with at least 24hrs of notice so that another patient can use this time. If you do not provide sufficient notice, you will be charged a "No Show" fee, which is equivalent to the cost of the treatment.

Payment Policy

We require payment at every visit. Accepted forms of payment include; cash, debit, Visa and Mastercard.

Consent for collection of personal information and privacy policy

I understand that in order to provide me with massage therapy services, Active Health Institute will collect some personal information about me. We are committed to collecting, using and disclosing your personal information responsibly.

Disclosure:

1. The patient's doctor/health practitioner(s)
2. Other health practitioners of the Active Health Institute for the purpose of supporting patient health.

I have reviewed Active Health Institute's Privacy Policy regarding;

- The collection, use and disclosure of my personal information
- The steps taken to protect my information
- My right to review my personal information

I understand how the Privacy Policy applies to me. I have been given a chance to ask questions I have regarding the Privacy Policy and they have been answered to my satisfaction.

Patient Signature: _____ **Date**: _____