Balanced Health Care

chiropractic . massage therapy . homeopathy . naturopathy . custom orthotics . customized training & rehab

Thank you for choosing us for your massage therapy needs. The information requested on these forms will assist us in treating you safely and effectively. Feel free to ask any questions about the information being requested. Please be advised that if you see more than one practitioner in our office, your health information will be shared only with the practitioners providing treatment to you. All information on these forms and in your file is confidential except as required or allowed by law or to facilitate assessment or treatment. You will be asked to provide written authorization for release of any information. If your health status changes in the future, please let us know.

Patient Name: _____ Date: _____

Home Address: _____ Postal Code: _____

Date of Birth: (E.g. Jan 1, 2005) _____ Age _____ Gender: F M Other

Home Telephone: _____ Work/Cell Telephone: _____
Can we leave a message here? Y N Can we leave a message here? Y N

Email: _____ Facebook? _____ Instagram? _____

Occupation: _____ How did you find us/Who referred you? _____

Emergency Contact Person: _____ Relation: _____ Phone #: _____

Family Physician _____ Family Physician's#: _____
May we contact him/her? Y N

What brings you to our office today? How long have you had this complaint? Has this happened before?

What is this injury/condition preventing you from doing?

Grade the intensity of your pain NOW 0 1 2 3 4 5 6 7 8 9 10
Grade the intensity of your WORST pain 0 1 2 3 4 5 6 7 8 9 10
Grade your level of stress 0 1 2 3 4 5 6 7 8 9 10

Have you had previous imaging for this Issue? (Eg. x-ray, CT scan, MRI): _____

Is this a WSIB case? Y N Is this a Motor Vehicle Collision? Y N
Date of Accident: (MMDDYY)_____ Date of Collision: (MMDDYY)_____

Please circle the following treatments (if any) that you have received for your complaint:

Medication Acupuncture Massage Physiotherapy Chiropractic Other

Current Medications/Supplements and the conditions they are treating: _____

_____

List any falls or accidents (and when): _____

Surgeries, internal plates, pins or artificial joints, and when: _____

Have you had massage before _____ When was your last massage? _____

What do you expect from your visit to our clinic? _____