

**Pura Vida Health Centre  
Medical History Form**

Please complete this form entirely. All information is strictly confidential. Please print.

Name (last, first) \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth (yyyy/mm/dd) \_\_\_\_\_ male \_\_\_\_\_ female \_\_\_\_\_

Resident Address \_\_\_\_\_

Postal Code \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_

Resident Telephone # \_\_\_\_\_ Business/Cell # \_\_\_\_\_

Occupation \_\_\_\_\_ # of years at occupation \_\_\_\_\_

Email: \_\_\_\_\_

Would you like to receive our quarterly updates? Y/N

How did you hear about Pura Vida Health Centre? :

referred By \_\_\_\_\_ Port Credit Arena \_\_\_\_\_ Other \_\_\_\_\_

List past surgeries including dates

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List past accidents/injuries including dates

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List current/recent medications and/or supplements with the reason for taking them

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What other forms of treatment have you undertaken, present/past and the reason

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Check off the following if they apply to your lifestyle

Smoking \_\_\_\_\_ Alcohol \_\_\_\_\_ Drugs \_\_\_\_\_ Stress \_\_\_\_\_ Poor Sleep \_\_\_\_\_

Is there anything that you think is important that relates to your complaint(s)

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Check any of the following if you have experienced them in the past or present

Osteoarthritis		Cancer (list type)	
Rheumatoid arthritis		Gout	
Family history of arthritis		Osteoporosis	
Diabetes (list type)		Multiple Sclerosis	
Family history of diabetes		Epilepsy	
Hepatitis (list type)		Emphysema/COPD	
Tuberculosis		Bronchitis	
Polio / post polio		Pneumonia	
HIV or AIDS (specify)		Kidney disease/failure	
Pelvic inflammatory disease		Fibromyalgia	
Hernia (list location)		Hemophilia	
Cerebrovascular accident		Irritable skin condition	
Myocardial infarction		Allergic reactions	
Angina		Buerger's disease	
Hypertension		Varicose veins	
Atherosclerosis		Spondylolysis/Spondylolisthesis	
Anemia		Neuritis	
Haemophilia		Flaccid Paralysis	
Ulcerative colitis/Chrons		Endometriosis	
Diverticulitis		Polyps	
Disc herniation or prolapse		Fibroids/Cysts (location)	

Check any of the following if you have experienced them in the past or present

Prolonged constipation		Tail bone injuries	
Ulcers		Colic	
Excess menstrual pain		Ear infections/aches	
Vision loss		Life threatening experience	
Long term corticosteroid use		Emotional distress	
Difficulty swallowing/speaking		Loss of strength	
Shortness of breath		Loss of consciousness	
Vertigo		Numbness	
Chest pain		Ligamentous laxity	
Scoliosis		Surgical implants (pins/plates etc)	
Headaches/migranes		Sinusitis	
Heart burn		Acid reflux	
Dental Surgery		Pain in the Face	

Are you pregnant? \_\_\_\_\_ Trimester \_\_\_\_\_ Do you have a pace maker? \_\_\_

List the reason(s) for your visit and the primary areas of concern

\_\_\_\_\_

Date of Last Medical Examination \_\_\_\_\_

**Pura Vida Health Centre**

**Informed Consent**

I (print name)\_\_\_\_\_ consent to manual osteopathic treatment, massage therapy or other therapy \_\_\_\_\_ for the following complaint(s): \_\_\_\_\_

I am aware that any form of therapy has the possibility for health benefit and risks. I have asked my about any questions and/or information relevant to my treatment for the above complaints. Alternate courses of treatment have also been discussed if applicable. By signing this form, I am aware that I may stop the treatment at any time.

Signature/Parent/Guardian\_\_\_\_\_ Date\_\_\_\_\_

**Cancellation Policy**

A minimum of 24 hours' notice must be given when canceling appointments. If less than 24 hours' notice is given, the client will be responsible for the cost of the cancellation fee based on the therapist's policy. No receipts will be given for the payment of missed appointments. Subsequent appointments will not be scheduled until payment is received.

Signature/Parent/Guardian\_\_\_\_\_ Date\_\_\_\_\_

**Privacy Policy**

Effective January 1 2004 the Personal Information and Electronic Documents Act (PIPED) requires businesses to control and protect the personal information that is collected from clients. Below are explanations as to who will see your information and why it is needed.

- Name, address, email and phone number are collected to be able to contact you if there are appointment changes, payment inquires or news/changes pertaining to the clinic if you so desire.
- Permission to contact doctor in the event that more details are needed pertaining to the condition being treated.
- Health questionnaire is collected to be sure to avoid any contraindications for the treatment you receive. It also provides information about the areas that need to be treated, therefore allowing the therapist to create the most appropriate treatment plan.

Signature/Parent/Guardian\_\_\_\_\_ Date\_\_\_\_\_