INNATE WELLNESS
NATUROPATHIC MEDICAL CENTRE

5 Quebec Ave
{High Park Station}
Toronto, ON M6P2T3
TEL: 416 760 9424
FAX: 416 760 0029
INNATEWELLNESS.CA

Personal Information

Today's Date	Name		Sex M F
Date of Birth (DD/MM/YYYY)	Age	Weight	Height
Address Email	Contact Information [h] [w] [c]	In case of emergency notify Contact number	
Innate Wellness will email you confirmation of your upcoming appointments. If you wish to be contacted by phone, please list the best number to contact you.			
Occupation	Employer		
How did you learn about Innate Wellness?			

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General Health Questionnaire

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested.

Please list your additional Health Care Providers (i.e. Medical Doctor, Chiropractor, Medical Specialist, etc.)

Name Occupation Phone	Name Occupation Phone	Name Occupation Phone

Are you currently receiving treatment from another health care professional? If yes, please list. Yes No

_____

List the major reasons you are seeking massage (include location on body) Since Cause, if known

_____ _____ _____
_____ _____ _____
_____ _____ _____

Have you received massage therapy before? Yes No

Please list **all** prescribed and over-the-counter medications, vitamins, minerals, herbs, etc. which you are **presently** using and what they are treating.

_____
_____
_____

Please list any hospitalizations, surgeries, or injuries along with the date they occurred.

_____
_____
_____

Do you have any internal pins, wires, artificial joints or special equipment (e.g. pacemaker)? If yes, please list.

_____
_____

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Please check the box and fill in the blank spaces for each of the symptoms you presently have.

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart attack
- ☐ Phlebitis/DVT/varicose veins
- ☐ Pacemaker or similar device
- ☐ Heart disease
- ☐ Stroke/CVA date:_____

Infections
- ☐ Hepatitis
- ☐ Skin conditions
- ☐ TB
- ☐ HIV
- ☐ Herpes

Head/Neck
- ☐ History of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Ear problems
- ☐ Hearing loss
- ☐ Tooth/Jaw/Ear pain
- ☐ Head Trauma date:_____

Female
- ☐ Pregnant due date_____
- ☐ Other gynecological conditions _____

Respiratory
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Smoker

Gastrointestinal
- ☐ Irritable bowel syndrome
- ☐ Colitis
- ☐ Gastroenteritis
- ☐ Crohn's disease
- ☐ Constipation

Accident/Injury
- ☐ Car Accident
- ☐ Work Related
- ☐ Physical Limitations _____ _____
- ☐ Other Symptoms_____ _____

Other
- ☐ Loss of sensation (location _____)
- ☐ Diabetes Onset _____
- ☐ Allergies/Hypersensitivity
  - Type of reaction _____
- ☐ Epilepsy
- ☐ Osteoporosis
- ☐ Cancer
  - (form/location) _____
- ☐ Skin condition _____
- ☐ Arthritis
- ☐ Other _____

Please list any family history of the above conditions.

_____

_____

_____

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Informed Consent

We would like you to understand the services we provide, the costs involved, and what we do with the personal information we obtain about you. If you have any questions about this, please ask. This informed consent begins today for the duration of treatment and is between the Registered Massage Therapist (RMT) and the person named at the end of this document.

Even the gentlest therapies may cause complications in certain physiological conditions. This depends greatly on the individual and the extent of the illness. It is very important, therefore, that you inform your RMT immediately of any disease process that you are suffering from, as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding, advise your RMT immediately. You will be assessed and tested before any treatments are applied. Health risks associated with Massage Therapy Treatment include, but are not limited to:

- Aggravation of pre-existing symptoms during the healing process;
- Muscle strains and sprains, bruising, light headed or dizziness, and tenderness;

Please check the box (☑) to indicate you have read and understand the following:

<u>Disclaimer of Health Care Related Services</u>

☐ I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques that may be recommended by my therapist.

☐ I understand that I will be draped at all times and the areas undraped will be secure to insure there is no indecent exposure. I am informed that I have the right to terminate the treatment at any time, and the right to alter the therapist's pressure during the massage treatment.

☐ I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I understand that massage therapy is not a substitute for a medical examination. I acknowledge that no guarantee has been provided to me as to the results of the treatment.

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Confidentiality

☐ I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

☐ I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy.

Payments & Appointment Etiquette

☐ I understand the fee schedule as stated below and I understand the 24 hour cancellation policy and agree to pay the missed appointment fee if I cancel within the 24 hour period preceding my appointment time. I understand Innate Wellness' lateness policy that I am responsible to pay for the time I reserved with the therapist, regardless of the time I arrive and I am ready for my appointment.

☐ I understand that I may purchase any recommended medicines or supplements from the dispensary at Innate Wellness or a pharmacy or retail store of my choice.

Patient Name _____ Signature _____ Date _____
(please print) (guardian if applicable)

Fee Schedule

Registered Massage Therapy

90 minute	125.00
75 minute	105.00
60 minute	85.00
45 minute	70.00
30 minute	50.00

Missed Appointment Fee (less than 24 hours business days' notice) **Full price of the appointment**

Prices are subject to HST.

We accept Cash, Visa, MasterCard, and Interac Debit.