Heather Macdonald RMT @ Yoga Source
16925 Yonge, Newmarket, ON L3Y 5Y1
(905) 830-9700

Client Information Form

Contact Information

First Name		Address ✉	
Last Name		City	
Birthday	M D Y	Postal Code	
Home ✆			
Business ✆			
Cell ✆			
Preferred ✆			
Email 💻			

Emergency Contact Information

Name	
Relation	
Home ✆	
Alternate ✆	

Physician Information

Family Dr.		Referring Dr.	
Family Dr. ✆		Referring Dr. ✆	
Family Dr. Address ✉		Referring Dr. Address ✉	

What brings you in today?

Have you seen a doctor about it?	❑	From a Motor Vehicle accident?	❑	Date of injury:
Is it a result of an injury?	❑	Or a Workplace accident?	❑	Claim number:
Or previously existing condition?	❑	Has the injury been reported?	❑	
		Who was the injury reported to?		

Cancellation Policy

In certain circumstances we may contact you to confirm or re-schedule your appointment. Please indicate your Preferred Contact) above. Should you wish to change your scheduled appointment, we ask that you give us 24 hours notice. If you do not notify us of appointment cancellation, you will be charged for your appointment. If your insurance does not cover any portion of treatment, you are responsible for full payment of the treatments.

Attestation

By signing below I attest that the information I've given is true to the best of my knowledge;

AND

- ❑ I have read, and agree to adhere to the cancellation policy as outlined above.
- ❑ I give my consent to assessment and treatment as explained to me by my Massage Therapist.

Signature ______________________ Date ______________________

The information collected here is confidential, protected under the *Personal Information Protection and Electronic Documents Act*, (PIPEDA) and will not be released without your consent except as required by law.

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Health History Form

Cardiovascular

- ❑ heart attack
- ❑ stroke /CVA
- ❑ high / low blood pressure
- ❑ chronic congestive heart failure
- ❑ Heart disease
- ❑ Varicose veins / phlebitis
- ❑ high cholesterol
- ❑ Pacemaker or similar device
- ❑ Is there a family history of any of the above?

Infections

Current (Previous)

- ❑(❑) hepatitis
- ❑(❑) TB
- ❑(❑) skin infections
- ❑(❑) herpes
- ❑(❑) plantar warts
- ❑(❑) measles
- ❑(❑) chicken pox
- ❑(❑) flu

Respiratory

- ❑ Chronic cough
- ❑ bronchitis
- ❑ asthma
- ❑emphysema
- ❑ Shortness of breath
- ❑ Is there a family history of any of the above?
- ❑ Smoking? How many per day?_______

Digestive

- ❑ constipation
- ❑ diarrhea
- ❑ other: __________________________

Joints & Muscles

- ❑ pain / stiffness
- ❑ swelling / bruising
- ❑ tear / strain / sprain
- ❑ loss of sensation / function
- ❑ osteoarthritis
- ❑ RA
- ❑ other: __________________________

Other

- ❑ vision and / or hearing problems
- ❑ headaches? Type:__________________
  Dr. diagnosed? ❑ Yes ❑ No
- ❑ diabetes? Onset?__________________
- ❑ Epilepsy? Type:___________________
  Frequency of seizures?
  ____
- ❑ Cancer? Where?____________________
- ❑ Allergies? To what? ________________
  ____
  What is your reaction? ______________
  ____
- ❑ Any pins, wires, artificial joints?
  What: ___________________________
- ❑ Skin conditions? __________________
- ❑ Any other conditions?
  ____

Women

- ❑ pregnant? Due:___________________
- ❑ complications?___________________
  ____
- ❑ gynecological conditions?
  ____
  ____
  ____

Affecting My

Left Side		Right Side
❑	Hands / Wrists	❑
❑	Arms / Elbows	❑
❑	Shoulders	❑
❑	Neck	❑
❑	Jaw	❑
❑	Upper back	❑
❑	Lower back	❑
❑	Hips / Pelvis	❑
❑	Legs	❑
❑	Knees	❑
❑	Ankles / Feet	❑

Men

- ❑ Testicular / prostate cancer
- ❑ other: ______________________

Surgeries / Injuries	Year	**Medications**	Conditions they treat

What can we do for you today? *Please tell us a little about your expectations of treatment*

Name ________________________ Signature ________________________ Date ________________

Please fill out this form to the best of your knowledge. Please feel free to ask us questions about the information we collect. The information we request here assists us in providing you with safe, effective treatment. This information is protected under the Personal Health Information Protection Act and will not be released without your consent except as required by law.