Synergy Health
working for you

Medical History Form

All information gathered is confidential

Patient Name: _____

If needed, do we have permission to contact your physician regarding your treatment at Synergy Health? Y/N

Does your physician know you intend on participating in treatment and/or an exercise program? Y/N

What is your current complaint/pain and when was the onset of symptoms?

_____

_____

What movements or activities are limited?

_____

_____

What, if anything makes your condition worse?

_____

_____

What, if anything makes your condition better?

_____

_____

Have you been involved in a car accident? Y/N If yes please state when and describe the accident._____

_____

Do you currently, or in the past have any of the following: If yes please describe.

_____

- Heart Problems
- Low/High Blood Pressure
- Chronic Illness/ Conditions
- Hernia
- Bone or Joint Issues
- Lung or Breathing Problems
- Diabetes
- Cancer
- Stroke
- Seizures
- Skin Disorders
- Fatigue/Depression
- Varicose Veins/Phlebitis
- Ruptured/Bulging discs
- Pins/Needles
- Infectious Conditions
- Headache/Teeth Grinding

When and by whom were you diagnosed with any of the above conditions/issues?

_____

Are you currently receiving treatment? Y/N If yes please describe_____

Do you have any history of surgery (dental and cosmetic included) Y/N. If yes please date and describe_____

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Are you currently or recently (last five months) pregnant? Y/N

Please list any medications you are currently taking, including vitamins/minerals/herbs.

_____

Have you been sedentary (inactive for the past year or more) Y/N

What is your occupation? _____

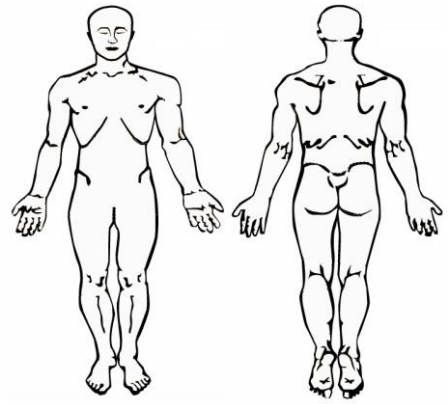
Please indicate your main occupational activities:

- Sitting
- Computer Work
- Driving
- Repetitive Movement
- Standing
- Lifting
- Bending
- Other_____

Do you exercise? Y/N If yes please describe the activities that you do_____

Is there anything else you feel is important that was not covered?

Please indicate on the diagram below any areas that you are experiencing discomfort/pain.



_____

Please be aware we have a 24 hours cancellation policy for all massage appointments. Otherwise you will be charged $25 for your appointment and/or the full amount of $100.

Patient Signature: _____ Date: _____

Massage Patients Only

What are your goals for massage therapy? _____

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Fax: 604-564-2040
www.synergyhealthgroup.ca
info@synergyhealthgroup.ca

New Patient Intake Form

Patient Full Name (Mr /Mrs /Miss /Ms):_____

Birthdate (Day/Month/Year):_____ Care Card #: _____

Telephone (Home):_____(Work):_____(Cell):_____

Home Address:_____ City:_____

Postal Code:_____ E-Mail Address:_____

Family Doctor: _____Phone:_____Fax:_____

Cancellation/No Show Policy

*Please provide us with your **credit card information** that will remain strictly confidential. A payment will only be charged to your credit card if we do not receive a 24 hours notice for cancellations and/or appointment no-shows. As appointments are of high demand, we value your scheduled appointments. Thank you for your co-operation.*

Credit Card (circle one): VISA / MASTERCARD

Digits: _____ Expiry Date: _____ 3-digit Code: _____

► **How Did You Hear About Us?**

☐ Doctor's referral ☐ Walked by the clinic
☐ Flyer ☐ Referral from Family or Friend
☐Website ☐Other: _____

Thank -you, we appreciate your feedback.

By providing us with your email address you are signing up for our monthly newsletter. You can unsubscribe at any time and we will never sell your email information to any third party agency.

Patient Signature:_____Date:_____

If the patient is under 16 years of age or if unable to sign due to medical reasons, a parent or guardian must sign below.

I, _____ am the parent/guardian of the above named patient and I consent to examination and treatment of this patient.

Signature of parent/guardian: _____