



2501 Spruce St. Van, BC V6H 2P8 604.732.5222 broadwaywellness.org

Confidential Patient History Form Today's Date _____

Name _____ **Birthdate** _____

Address _____ **Phone 1** _____

Phone 2 _____

Occupation _____

Email _____ **Referring Provider** _____

Please check this box if you would like to receive our newsletter. We enjoy sharing information, and will send you a short article with interesting, up to date wellness, clinic, and promotion information about 4-6 times per year. Your email will be used for this purpose only, with the option to unsubscribe imbedded into each newsletter.

MEDICAL HISTORY

Please list any Medications you presently take _____

Known allergies _____

Please list all major accidents to date _____

Please list all surgeries to date _____

Please list all major illnesses to date _____

Please list all broken bones to date _____

Are you pregnant? Yes/No If yes, how far along? _____

Do you have any foreign bodies ie: IUD, pacemaker, metal screws or plates, wire mesh (hernia repair) – please circle or list other(s) here _____

Circle any other therapy / treatment you are presently receiving
Massage Therapy / Chiropractor / Physiotherapy / Naturopath / Acupuncture / other _____

Please comment on level of fitness and forms of activity _____

CURRENT CONDITION

Please describe your current condition and symptoms _____

How long have you had this condition? _____

How did it start? _____

Please check (√) conditions you are experiencing presently and circle conditions you have experienced in the past.

SKIN: Rashes / bruise easily Other _____

MUSCLES / TENDONS / LIGAMENTS: Weakness or loss of strength Osteoporosis / osteopenia

Rheumatoid arthritis

Osteoarthritis Tendonitis Sprain / strain other _____

RESPIRATORY Asthma Bronchitis Difficulty breathing Emphysema

Smoking Other _____

CARDIOVASCULAR:

High / low blood pressure Heart attack Stroke Poor circulation

Other _____

HEAD AND NECK: Visual impairment Hearing impairment Speech impairment Headaches / Migraines

Jaw pain (TMJD) Sinus problems Other _____

OTHER: Diabetes Cancer Fainting Fever Insomnia Numbness / tingling Stress Depression

Anxiety Other: please comment _____

GI TRACT: Constipation / Diarrhea Gas Painful elimination Other _____

CANCELLATION POLICY AND CONSENT FOR TREATMENT:

The therapists at this clinic run their own practices, and receive their sole source of income from the treatments they provide for you. Your appointment time has been reserved especially for you. In courtesy to your therapist, and fellow patients, we require that you provide us with **24 hours notice** of any cancellation, or change of appointment time. In the absence of 24 hours notice, you will be charged the full cost of your treatment, unless we are able to fill your appointment with another client, in which case, you will not be charged. Also, therapists at this clinic are opted out. This means payment for all treatments, whether private or insured, is ultimately the responsibility of the patient.

"I authorize Broadway Wellness Centre and it's associated RMT to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission. I understand and accept the conditions listed above outlining the Broadway Wellness Centre's cancellation policy and I give full consent for treatment".

Signature: _____ **Date:** _____