Compass Health
2242A Bloor St. W, M6S 1N6, Toronto, ON
info@compassbloorwest.com | (416) 766 1200

Patient Intake Form

Name: _____ Date: _____
Address: _____ Email: _____
Tel: _____ Tel: (other) _____ Date of birth: _____
Occupation: _____ How did you find us? _____
Main interest for today's visit? ☐ Chiropractic ☐ Massage ☐ Orthotics ☐ Acupuncture ☐ Compression Stockings
Reason for seeking treatment: _____ Is this your first massage or chiropractic treatment? ☐Yes ☐No
Did a health care professional refer you for treatment? ☐Yes ☐No _____

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

Is there a family history of any of the above? ☐Yes ☐No

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

Is there a family history of any of the above? ☐Yes ☐No

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

Other Conditions
☐ Loss of sensation, where? _____
_____
☐ Diabetes, type? _____
☐ Allergies/hypersensitivity, to what? _____
Type of reaction: _____
☐ Epilepsy
☐ Cancer, where? _____
_____
☐ Skin conditions, what? _____
_____
☐ Arthritis

Is there a family history of arthritis? ☐Yes ☐No

Head/Neck
☐ History of headache
☐ History of migraines
☐ Vision problems
☐ Vision loss
☐ Ear problems
☐ Hearing loss

Women
☐ Pregnant, due? _____
☐ Children, number? _____
Ages _____
☐ Gynecological conditions, what?
_____

Substance Use
Cigarette use? ☐Previously ☐Currently
How long? _____ Quit date? _____
Alcohol use (drinks/week): _____

Lifestyle
Typical diet? _____
Exercise/frequency: _____
Sleep (hours/night): _____
Sleep position? ☐Front ☐Side ☐Back

Current Medications: _____
Condition it treats: _____
Are you currently receiving treatment from another health care professional? If yes for what? _____
_____
Surgery, date: _____
Nature: _____
Injury, date: _____
Nature: _____

Do you have any other medical conditions? ☐Yes ☐No
If yes, what? _____
Do you have any internal pins, wires, artificial joints or special equipment? ☐Yes ☐No
What? _____
Where? _____
How would you describe your overall health? _____
Primary Physician: _____
Contact details: _____
☐Referred by current patient, patient's name: _____

Navigate your wellness journey

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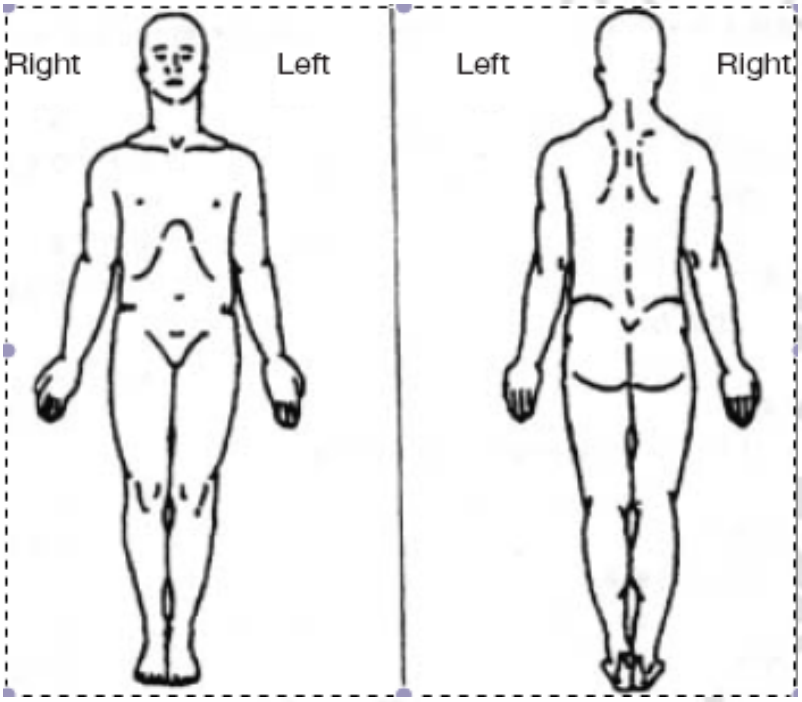
Current Symptoms

Please rate your pain intensity: 10 9 8 7 6 5 4 3 2 1 0 *(0 = no pain)*
When did it start? _____ How? _____
Is it getting **better, worse** or **staying the same**? _____
Is it worse in the morning/ daytime/ evening? _____

Indicate with an **X** on the diagram below, the location of your pain.



Describe the character of your pain *(check all that apply):*
☐ Dull/achy
☐ Stiff/tight
☐ Sharp/stabbing
☐ Numbness/tingling
☐ Burning
☐ Catching
☐ Other: _____

What makes it worse?
_____
_____

What makes it better?
_____
_____

Notes (*Internal Use*): _____
_____
_____
_____
_____

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CREDIT CARD AUTHORIZATION AND CONSENT FORM

I _____ hereby authorize Compass Health to charge my credit card due to an outstanding payment, not having any Extended Health Insurance Coverage, Missed Appointment and/or Late Cancellations made in **less than 48 hours** of the appointment time. A team member from Compass Health will contact me at the time of the transaction, to make me aware of any charges made.

PLEASE BE AWARE: LATE CANCELLATIONS AND MISSED APPOINTMENTS WILL BE CHARGED FULL TREATMENT AMOUNTS

Type of Card: ☐ MasterCard ☐ Visa (NO Debit Visa Allowed)
Credit Card Number: _____
Expiration Date: _____
CVV: _____
Name of Cardholder: _____
Authorized Signature of Cardholder: _____

By signing this form, I acknowledge the charges described hereon and assume full responsibility for said charges and agree to honor and abide by the terms of payment. I acknowledge and accept Compass Health Terms and Conditions.

Client Signature: _____
Date: _____