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

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:
☐ Gynecological conditions, what?
_____

Substance Use
Cigarette use?
☐Never ☐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: _____

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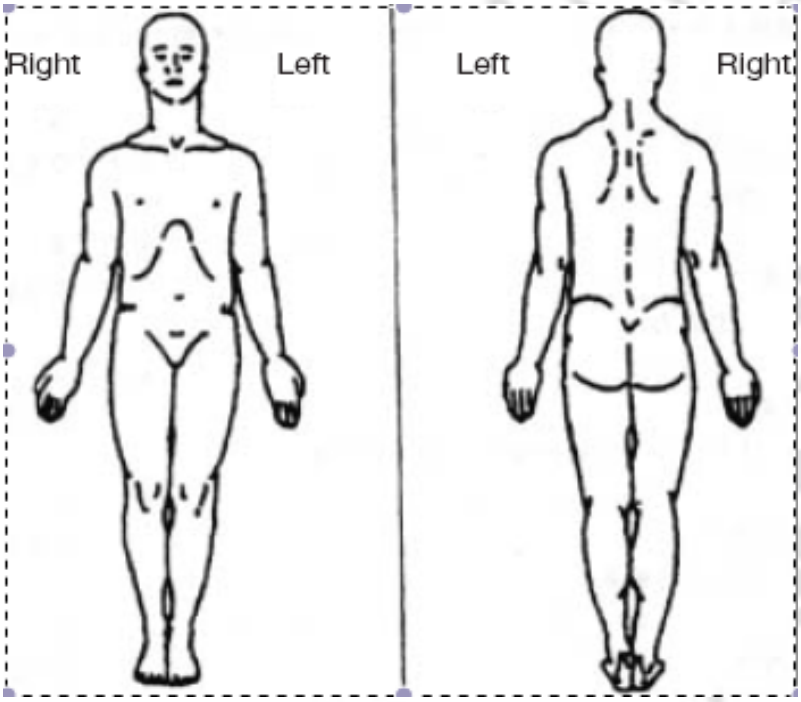
Current Symptoms

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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Privacy Code and Informed Consent: Registered Massage Therapy

Personal Information
Personal information is information about an identifiable individual. Generally, the information we collect is limited to name, home contact information, gender and age. As part of your patient file, we retain your health history, health measurements and examinations results, health conditions, assessment results and diagnosis, the health services provide to you or received by you, your prognosis and other opinions formed, compliance with treatment and the reasons for your discharge and discharge recommendations. We may also maintain records for payment and billing purposes. Only necessary information is collected about you. We only share your information with your consent, the use, retention and destruction of your personal information complies with existing legislation and privacy protection protocols. Privacy protocols comply with privacy legislation, standards of our regulatory body, the College of Registered Massage Therapists of Ontario and the law.

Disclosure of Personal Information
Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we outline below how the clinic will use and disclose information.

- To deliver safe and effective patient care
- To enable use to contact you
- To communicate with other health care providers
- To complete and submit claims on your behalf to third party players
- To comply with legal regulatory requirements under the Massage Therapy Act and the Regulated Health Professions Act
- To process payments and collect unpaid amounts

Informed Consent
I hereby request and consent to the service of massage therapy treatment and other massage procedures, including various modes of remedial exercise and hydrotherapy, on me by the registered massage therapist.
I understand that I will have an opportunity to discuss with the massage therapists and/or with other office or clinic personnel, the nature of massage therapy treatment and other procedures.
I understand the results may not be guaranteed.
I am informed that, as in all health care, in the practice of massage therapy there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, bruising, light headed or dizziness, and tenderness.
I do not expect the massage therapist to be able to anticipate and explain all risks and complications and I wish to rely on the massage therapist to exercise judgment during the course of the treatment which the massage therapist feels at the time, based upon the facts then known, and is in my best interests.
I understand that I will be draped at all times and the areas undraped will be secure to insure there is no indecent exposure. If undraping my gluteals is significant in the treatment I do understand that it is part of the therapy.
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 have read the above consent. I have also had an opportunity to ask questions about its consent, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of the treatment for my present condition and for any future condition(s) for which I seek treatment.

Client name: _____ Date: _____

Client signature: _____ Therapist signature: _____

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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: _____