CONFIDENTIAL PATIENT HISTORY FORM

PLEASE EMAIL THIS FORM BACK TO INFO@EWCENTRE.COM

ELYSIAN WELLNESS CENTRE

Date of Initial Health History _____
Update 1 _____
Update 2 _____
Update 3 _____
Update 4 _____

Name _____ **Birthdate** _____
(month / day / year)

Address _____ **Family Doctor** _____
City/Prov _____ Phone and Address _____
Postal Code _____ **Referring Professional** _____
Phone (home) _____ Phone _____
(cell/pager) _____
(work) _____

Insurance Name _____
Email _____ Policy Number
Occupation _____ **Member ID**

Emergency Contact Name and Number _____

How did you hear about our clinic? _____

Please indicate if you believe if any of the following apply to you? (P = past C = current)

- _ Heart Attack
- _ High / Low Blood Pressure
- _ Stroke or Aneurysm
- _ Pace Maker
- _ other Heart condition
- _ Varicose Veins
- _ Bruise easily
- _ other Circulatory condition
- _ Thyroid High / Low
- _ Diabetes
- _ Kidney Disease
- _ other Urinary condition
- _ If Pregnant When Due?
- _ Gynaecological Condition
- _ Headaches / Migraines
- _ Dizziness / Fainting
- _ Nausea
- _ Spinal Injury
- _ Head Injury
- _ Epilepsy / other seizures
- _ other Neurological condition
- _ Loss of Sensation, where?
- _ Asthma
- _ Chronic Sinusitis
- _ other Respiratory condition
- _ Fibromyalgia
- _ Irritable Bowel / Colitis
- _ Digestive condition
- _ Skin condition
- _ Joint Dislocation
- _ Bone Fracture
- _ Arthritis
- _ Osteoporosis
- _ Rods / Pins / Plates / Shunts
- _ Implants _____
- _ Transplant _____
- _ Corrective Lenses/Contacts
- _ Hearing loss or ear problems?
- _ Cancer _____
- _ Hepatitis
- _ HIV
- _ other Contagious condition

_____

- _ Mental Health Concern:

Please list any Medications you presently take:

_____

_____

Known Allergies (including medications, foods, seasonal, oils and lotions, etc.)

_____

Do you have any family history of medical conditions? ❑ **Yes** ❑ **No**

Please list: _____

Have you ever been hospitalized, had any major accidents, illnesses, or surgeries? ❑ **Yes** ❑ **No**

Please comment: _____

_____

Continued on next page --->

Other therapy / treatment: (past or present, does not have to be related to this visit)

- ❑ Massage Therapy
- ❑ Chiropractor
- ❑ Physiotherapy
- ❑ Naturopath
- ❑ Acupuncture
- ❑ Other _____

List any Activities, Sports, Hobbies
(ie. Jogging, Hockey, Crafts, Computer, etc)

_____

_____

_____

List any **NON-prescription vitamins, minerals or other supplements** you are taking:

_____

_____

_____

Please CIRCLE the answer closest to how you PRESENTLY feel: (1 = poor, 5 = excellent)

Quality of Sleep	1	2	3	4	5
Energy Level	1	2	3	4	5
Eating Habits	1	2	3	4	5
Stress Level	1	2	3	4	5
Exercise Habits	1	2	3	4	5

Hours of sleep per night (approx.) ___

Number of meals you regularly eat per day ___

Number of times you exercise per week ___

Smoker	Yes	No	Occasional
Alcohol	Yes	No	Occasional

Reason for Initial Visit

Please describe your current condition & symptoms along with how long you have had this/these issue(s):

_____

_____

_____

AGREEMENT TO CLINIC POLICIES

Your appointment time has been reserved for you. We ask that you provide us with 48 hours notice of cancellation or re-scheduling for all physical therapy treatments, and 48 hours for dietitian services (pre-paid follow-ups are non-refundable and may only be re-scheduled above 48 hours of your appointment time). For physical therapy, cancellations between 24h-48h of your appointment time are charged 50% of the service fee. Cancellations under 24h and missed appointments are charged 100% of service fee. Payments for all treatments and sessions are the responsibility of the patient, whether insured or not. I verify the information I have stated in this form to be true and correct, and I am aware any false information provided is punishable by law. I acknowledge any individual not following COVID-19 protocols in place will be asked to leave the premises.

I authorize Elysian Wellness Centre and its associated staff to collect my personal and medical information as documented above in order to contact me. Information provided will be kept confidential unless required by law or a consent form is signed by the patient. We also reserve the right to confirm with your insurance company the dates of attendance, as they occasionally audit claims. All information I, the patient, provided on this form is true and correct.

I authorize Elysian Wellness Centre to contact me via email/text to remind me of my appointment(s) and any communication on scheduling, treatments, and account balances.

I authorize Elysian Wellness Centre to charge my credit card for any late cancellations, missed appointments, or balances due for services rendered or products purchased.

All balances 30 days past invoiced date will be passed on to collections and are subject to a 30% fee along with an interest rate of 3%/monthly.

_____ _____

Patient Signature **Date**