Goodwill Healing

Applied Clinical Therapeutics

747 Hyde Park Rd., Suite 111
London, Ontario

Please complete this Health History form as accurately as possible. These four pages will help to ensure that you receive a safe and effective treatment. If at any time your health status changes please let us know as soon as possible prior to your treatment. All information is strictly confidential and cannot be released to anyone without your written consent.
If at any time you have any questions, feel free to ask.

Name: _____

Address : _____

City_____ Postal Code _____

Home Phone:_____

Work Phone:_____

Cell Phone:_____

E-Mail : _____

Age_____ Date of Birth : _____ Ht: _____ Wt: _____

Occupation : _____

Family Physician: _____Phone: _____

Emergency Contact:_____ Phone:_____

Where did you hear about this clinic? _____

Please describe your primary concern (reason for treatment)

_____
_____
_____
_____
_____

Health Care Benefits / Group Insurance for Osteopathy? Yes / No
Health Care Benefits / Group Insurance for Massage Therapy? Yes / No
Health Care Benefits / Group Insurance for Counselling? Yes / No
Health Care Benefits / Group Insurance for Naturopath? Yes / No

Please place a checkmark next to any of the areas that apply to your health history

Head and neck

__Headache
Type:_____
__Dizziness
__Earaches
__Neck Pain

Muscle & Joint

__Pain
__Stiffness
__Swelling
__Limited motion / fatigue
__Osteoarthritis
__Osteoporosis
__Osteopenia
__Rheumatoid Arthritis
__Back Pain
Upper__ Mid__ Lower__
__Shoulder Pain (L) or (R)
__Elbow pain (L) or (R)
__Wrist pain (L) or (R)
__Hip pain (L) or (R)
__Knee pain (L) or (R)
__Ankle pain (L) or (R)

Respiratory

__Bronchitis
__Emphysema
__Asthma
__History of Pneumonia
__History of TB
__Chronic Cough

Skin

__Sensitive skin
__Rashes
__Acne
__Cold sores
__Bruise easily
__Varicose veins
__DVT
__Eczema / Psoriasis
__Recent tattoos
__Recent piercings
__Infections or tumors

Infectious diseases

__Tuberculosis
__HIV / AIDS
__Hepatitis A, B or C

EENT

__Vision loss
__Cataract
__Eye surgeries
__Tear duct dysfunction
__Tinnitus
__Chronic sinusitis
__Difficulty swallowing

Cardiovascular

__High blood pressure
__Low blood pressure
__Poor circulation
__Heart disease
__Heart surgery
__Pacemaker
__Stroke

Women

Menstruation
__Heavy
__Moderate
__Light
__Painful
__Medicated

If you have had any problems with the following organs / systems of the body, please elaborate in the space provided

1) Eyes, ears, nose, throat_____
2) Lungs_____
3) Skin_____
4) Breast_____
5) Digestive organs_____
6) Liver / Gallbladder_____
7) Pancreas_____
8) Spleen_____
9) Lymphatics / circulatory_____
10) Reproductive_____

Regarding Children:

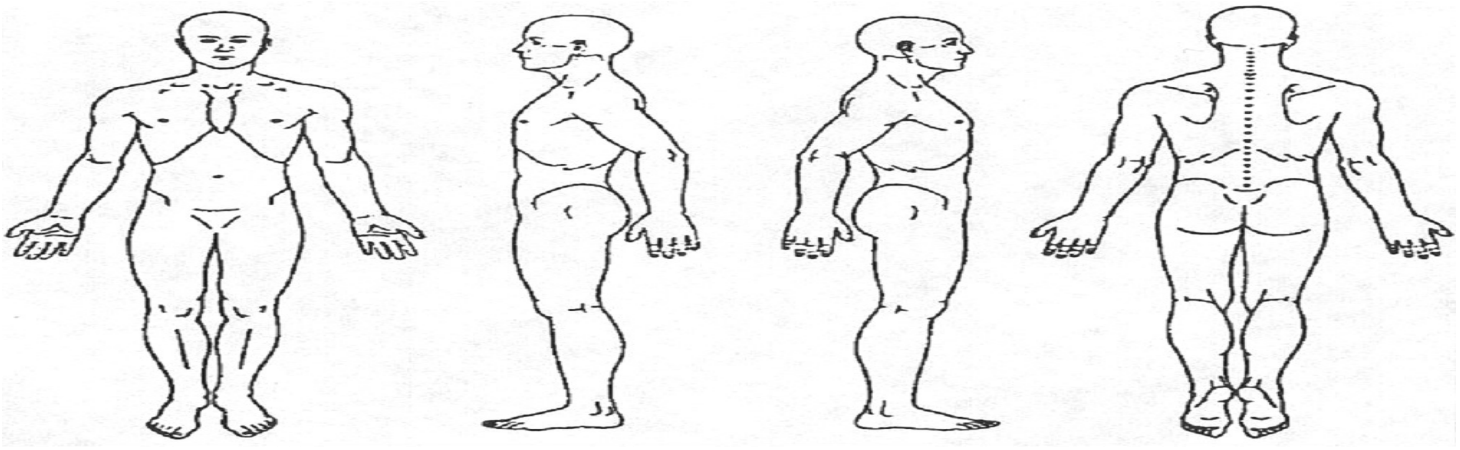
Do you have any children? If yes, how many?_____
Have you had any complications with conception? _____
Have you had any c-sections? If yes, how many? _____
If you have had any complications or concerns since delivery please list / explain: _____
_____

List pharmaceutical medication_____
_____

List Herbal medication:_____
_____

Date of last full physical and any findings of concern;_____
_____
_____

Please use the diagrams below to illustrate the areas of your body which have been severely injured, cause regular pain, discomfort, swelling or dysfunction.



Please list any pins, wires, plates or implants:

Please list any surgeries:

In the following sections, please choose a number that best describes your current status:
0 being poor or low and 10 being exceptionally high or above average.

Physical Activity: 0…..1…..2…..3…..4…..5…..6…..7…..8…..9…..10
How do you maintain your level of physical fitness / activity?

Discomfort : 0…..1…..2…..3…..4…..5…..6…..7…..8…..9…..10
How does your primary complaint effect your ability to perform daily activities of living or work?

Social, environmental wellbeing

A) Stress level: 0.....1…..2.....3…..4…..5.....6…..7…..8.....9…..10
B) Social / emotional support: 0….1…..2….3…..4…..5….6…..7…..8.....9…..10
C) Vitality / energy: 0….1…..2….3…..4…..5….6…..7…..8.....9…..10
D) Rest / sleep: 0….1…..2….3…..4…..5….6…..7…..8.....9…..10
E) Diet / Nutrition: 0….1…..2….3…..4…..5….6…..7…..8.....9…..10
F) Hydration: 0….1…..2….3…..4…..5….6…..7…..8.....9…..10

Please use this space to further elaborate about the social, environmental section choices if required:

In addition to treatment, which areas of your health would you like to commit to improving over the next year?

What other therapeutics have your tried previously?

What are your goals and expectations in regards to treatment?

Goodwill Healing

Office policies, standards and commitment to practice
747 Hyde Park Rd. London On. Suite 111

Please read this document carefully, initial beside each point and sign at the bottom of the page.

1. ____ All information written or discussed is completely confidential and cannot be discussed or shared with anyone without your verbal and written consent. It is advised to consult your physician prior to any changes in your diet, exercise or therapeutic protocol if you have any significant concerns about your health status.
2. ____ If you are receiving treatment from another practitioner at Goodwill Healing, we will discuss your case in order to provide you with the best treatment protocol possible.
3. ____ All therapists / practitioners working at Goodwill Healing Inc. are completely independent practitioners who constantly upgrade their education and are insured as a separate entity onto themselves. A new Health History form and initial intake may be required prior to seeing another practitioner so that a safe, effective and efficient treatment may be properly rendered.
4. ____ Reminder calls are not office policy due to the lack of secretarial staffing, however your appointment will be written out for you. Please note that digital reminders on phones and other devices often erase appointments when updates happen. Missed appointments or late arrivals due to technological error with your device will be charged as a missed appointment. It is therefore suggested that you create a hard copy or use alternate devices as a reminder to reduce the potential of this situation occurring.
5. ____In the case of late arrivals, it is fully understood that only the time remaining for your scheduled appointment will be allotted to provide treatment. A full charge for the appointment will be levied.
6. ____ Missed appointments without 24 hours notice will be charged the **full allotted fee** for the appointment scheduled unless in the case of a family emergency or severe illness. Please keep in mind that some individuals who attend our clinic for treatment have a severely compromised immune system. If you are sick with an acute illness where you are clearly running a fever or are contagious, kindly reschedule your appointment with as much notice as possible via phone call, text or e-mail. Giving plenty of notice allows others who are currently on a waiting list the opportunity to receive treatment and is respectful to the therapist or practitioner at the clinic.
7. ____ The practitioners at Goodwill Healing do not work through any cases that are currently involved in WSIB, MVA or any claims that are litigious in nature. In signing this document, you understand that we will not be providing letters or documentation that are for legal or medical purposes. If you do require a letter regarding your clinical case it is suggested that you contact your primary medical practitioner or family doctor. If a letter is absolutely necessary in regards to your clinical case; one may be written by your practitioner for a cost of $250.00 plus HST which must be paid in full within 30 day by yourself or your firm.
8. ____ Payment may be made in the form of a personal cheque, e-transfer or cash to the practitioner rendering treatment or service provided. We do not take payment using debit cards, Visa, MasterCard or direct payment though your provider. Payment must be made on the day of service rendered. Cheques returned to the practitioner NSF or otherwise void will be charged a $25.00 service fee in addition to the previous cost of the service rendered by the practitioner. All accounts must be paid in full before month's end.
9. ____ The practitioners / therapists at Goodwill Healing do not and cannot render a "medical diagnosis" nor advise you on surgeries, medical procedures or medications. If you have any questions on these topics, please discuss them with your primary health care provider. If you have any changes in your health status, please advise us Immediately or prior to treatment as it has a direct effect on the way we will approach your treatment.
10. ____ In signing this document, you are giving full consent to assessment and treatment on this date and for any treatments that may follow. You are aware that you are taking on full responsibility for any and all of the possible effects that may take place during or following the treatment today or in the future.
11. ____In signing this document you are in agreement to all the terms and policies of this office and have disclosed all information throughout the health history form and initial consultation.
12. ____ Patients / Clients under the age of 18 must have a parent or legal guardian accompanying them for the initial assessment / treatment. If a client is under the age of 16 a parent or legal guardian must be present for all assessments and treatments that may follow.

Name:_____
Signature:_____
Signature of Parent or Guardian if under 18 years of age: _____
Date:_____