brio LIVING™

BODYWORK INTAKE FORM

Date _____

First name _____ Last name _____

Age _____ Date of birth (mm/dd/yy) _____ Female/Male _____

Care Card # _____ Occupation _____

Address _____ City/Province _____

Postal code _____ Email _____

Phone (home) _____ Phone (cell) _____

How did you hear about the clinic? _____

REVIEW OF SYMPTOMS

Major complaints in order of importance for you.	Since?	Causes?
1.		
2.		
3.		

CONTEXT OF CARE

I am interested in:

- ◯ Phase 1: Breaking the pain cycle
- ◯ Phase 2: Body repair and re-alignment
- ◯ Phase 3: Optimal health, maintenance and prevention
- ◯ I would like brio to select the type of care appropriate for my condition

CANCELLATION POLICY

I understand that I am responsible for paying the cost of the visit, before the next appointment, if I do not give 24 hours notice by phone of change or cancellation. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

CONSENT

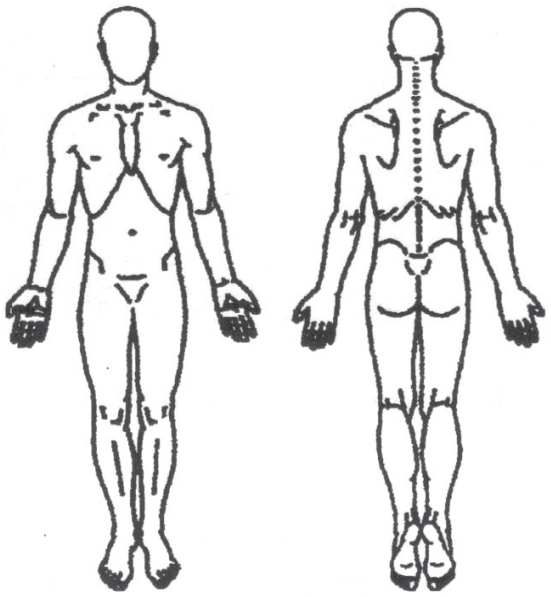
I hereby consent to receive treatments by the practitioners at Brio Integrative Health Centre. I understand that this consent is voluntary and may be revoked by me at any time. I authorize the clinic and its associated practitioners to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contacted numbers I have provided.

I consent to receiving ◯ phone calls/messages from Brio ◯ email messages from Brio
Please add me to the newsletter list. ◯ Y ◯ N

Signature _____ **Date** _____

Medications you presently take. (Please list)

Please indicate painful or distressed areas.
Please circle location(s) on picture.



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

Do you have any family history of medical conditions? ◯ Y ◯ N

Please list.

Have you ever been hospitalized, had any major accidents, illnesses, traumas or surgeries? ◯ Y ◯ N

Please comment.

Have you had any mental/emotional trauma? ◯ Y ◯ N

Please comment.

OTHER THERAPIES/TREATMENTS

(Past and Present)	Date	Practitioner	Reason
◯ Massage therapy			
◯ Chiropractic			
◯ Physiotherapy			
◯ Naturopathic			
◯ Acupuncture			
◯ Low level laser therapy			
◯ Other			

List any activities, sports, or hobbies (I.e. jogging, hockey, crafts, computer, etc.)

List any non-prescription vitamins, minerals or other supplements you are taking.

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 Aneurism
____ Pace maker
____ Other heart condition

_____

____ Varicose veins
____ Bruise easily
____ Other circulatory condition

_____

____ Diabetes
____ Kidney disease
____ Prostatitis
____ Other urinary condition

_____

____ Headaches/Migraines
____ Dizziness/Fainting
____ Nausea
____ Spinal injury
____ Head injury
____ Epilepsy/Other seizures
____ Other neurological condition

_____

____ Asthma
____ Chronic cinusitis
____ Other respiratory condition

_____

____ Irritable bowel syndrome
____ Digestive condition
____ Skin condition
____ Joint condition
____ Bone fracture
____ Arthritis
____ Osteoporosis
____ Surgery
____ Thyroid issues
____ Diabetes
____ Gall stones
____ Pregnant _____ weeks
____ Cancer

_____

____ Hepatitis
____ HIV
____ Other contagious condition

_____

OPTIONAL SECTION

Stress at your birth. (Please check any that apply).

____ Drugs/Medicine/Tobacco/Alcohol in pregnancy
____ Labor chemically induced
____ Forceps/Vacuum extraction/C-section
____ Premature delivery
____ Vaccine reactions
____ Falls in first year of life
____ Other health related problems

Comments _____

_____

Stress associated with childhood. (Please check any that apply).

____ Falls or injuries
____ Allergy/Asthma or Respiratory problems
____ Ear infections
____ Digestive problems
____ Hyperactivity
____ Other health related problems

Comments _____

_____

Please describe sleep routine: _____

_____

Please describe majority of daily diet (ex. home-cooked foods, fast food, prepackaged foods etc): _____

_____

Welcome! Our team looks forward to providing you with the best possible care.