MiracleHealth

7 Days Open: 9 AM to 8 PM
Unit 109 - 3000A Lawrence Avenue East,
Scarborough, Toronto, Ontario M1P 2V1

Phone: +1 (416) 289-4444
Email: info@miracle-health.ca

Medical History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

PLEASE PRINT

Name: _____ Phone # (H) _____ (B) _____

Address: _____

Date of Birth: _____ Occupation: _____ Source of referral _____

What is your chief complaint? _____ How is your health in general? _____

Please indicate conditions you are experiencing or have experienced:

HEAD

- ☐ headaches
- ☐ migraines
- ☐ vision problems/loss
- ☐ earaches/hearing loss
- ☐ jaw problems

RESPIRATORY

- ☐ smoking
- ☐ chronic cough
- ☐ emphysema
- ☐ asthma
- ☐ bronchitis
- ☐ shortness of breath

CARDIOVASCULAR

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chronic congestive heart failure
- ☐ history of heart disease/MI
- ☐ phlebitis/varicose veins
- ☐ stroke/CVA
- ☐ pacemaker or similar device
- ☐ heart attack
- ☐ other: _____

WOMEN

- ☐ pregnant, due: _____
- ☐ gynecological conditions, what? _____

MUSCLES/JOINTS

- ☐ neck
- ☐ mid-back
- ☐ lower back
- ☐ shoulders
- ☐ leg: left/right
- ☐ other: _____

_____

_____

INFECTIONS

(Hepatitis, TB, HIV, AIDS and other)

_____

_____

SKIN CONDITIONS

_____

_____

SURGERY

type: _____
date: _____
current symptoms: _____

_____

INJURY

type: _____
date: _____
current symptoms: _____

_____

OTHER CONDITIONS

- ☐ digestive problems
- ☐ constipation
- ☐ epilepsy
- ☐ loss of sensation
- ☐ liver/gall bladder problems
- ☐ kidney problems
- ☐ diabetes
- ☐ allergies/hypersensitivity reaction
- ☐ cancer
- ☐ arthritis
- ☐ hemophilia
- ☐ osteoporosis
- ☐ mental illness
- ☐ internal pins, wires, artificial joints or special equipment

where? _____

- ☐ other: _____

CURRENT MEDICATION

name use

_____

_____

_____

_____

MEDICAL DOCTOR

Name: _____
Address: _____
Phone #: _____

I understand that the information I give on this form will be confidential and will be used for no other purpose than medical professional's clinical records. The information given by me on this form is accurate to the best of my knowledge, and I understand that will be used by the medical professional in determination of treatment which is appropriate for me. It is my responsibility to update this information as it changes.

Date: _____ Signature: _____

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CONSENT TO TREATMENT

Patient's name: ..... Date: .....
(NAME PRINT)

Address:

.....

.....

1. This is to acknowledge that I have been informed on the nature of recommended plan of treatment as well as alternative courses of action and I understand that:

-any treatment or advice provided to me as a patient of this clinic is not mutually exclusive from any treatment or advice that I may now be receiving or may in the future receive from another health care provider

-I am at liberty to seek or continue medical care from a medical doctor or other health care provider

-the treatment and therapies rendered or recommended by this clinic may be different than those usually offered by a medical doctor or other health care providers

2. I authorize and consent to treatment by this clinic

3. I agree to pay my full account at the time of each visit or treatment, including fee for services, cost of supplements and remedies, cost of laboratory tests and other fees.

Dated this .....day of ....., 200 ..... .

.....
(PATIENT'S SIGNATURE)