

Date: _____

Name: _____ Birthdate (m/d/y): ____/____/____ Female Male

Address: _____

City: _____ Prov.: _____ Postal Code: _____

Phone #'s: Home: _____ Work: _____ Cell: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Best place to leave a message? Home Work Cell E-mail Address: _____

Age: _____ Weight: _____ Height: _____ Physician: _____

Employer: _____ Occupation: _____

How did you hear about us? _____

Do you exercise regularly? Yes No Any limitations with your program? Yes No _____

Do you have any areas of **weakness, pain, or muscle tension**? Yes No _____

Any **falls, accidents, or injuries** in the last five years? Yes No _____

Are you currently under a **physicians care**, including restrictions, for **any** reason? Yes No

Other **health care professionals**? Yes No _____

Drugs or supplements you are taking: _____

Health Conditions – Check if YES (current or past)		
<input type="checkbox"/> Anemia	<input type="checkbox"/> GI Problems	<input type="checkbox"/> Neck pain / tension
<input type="checkbox"/> Aneurysms	<input type="checkbox"/> Heart condition	<input type="checkbox"/> Over-weight
<input type="checkbox"/> Asthma	<input type="checkbox"/> Headaches	<input type="checkbox"/> Obesity
<input type="checkbox"/> Allergies or sinus	<input type="checkbox"/> Hernia	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Osteoporosis/skeletal health
<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Carpal Tunnel Syndrome	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> IBS	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Chronic Fatigue Syndrome	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Rotator Cuff Injury
<input type="checkbox"/> COPD	<input type="checkbox"/> Joint injury or pain	<input type="checkbox"/> Smoking
<input type="checkbox"/> Crohn's	<input type="checkbox"/> Low back pain	<input type="checkbox"/> Spinal injury
<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Lymphodema	<input type="checkbox"/> Stroke
<input type="checkbox"/> Pre-Diabetic	<input type="checkbox"/> Malnutrition	<input type="checkbox"/> Surgeries (any type)
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Menstrual Irregularities	<input type="checkbox"/> Tendonitis
<input type="checkbox"/> Fainting	<input type="checkbox"/> Menopause	<input type="checkbox"/> Thyroid Condition
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Metal Implants	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Fractures	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Other



Privacy Policy and Information Release Authorization

Why we collect personal information

One to One Wellness professionals collect personal information about our clients for the purpose of providing therapeutic treatment, safe training, useful information, and timely accounting. We add client contact details to our database to send newsletters, promotional offers, and other materials of interest. Clients may opt-out of these services at any time by automated means or by contacting our administrative staff.

What kinds of information we collect

We collect a wide variety of personal information in connection with our services. This is primarily related to contact information and medical / health history.

How we collect personal information

Most of the personal information collected by us is provided directly by the individual. In some cases, information is provided by a related organization or other health care professionals.

Confidentiality

Our clinic adheres to high standards of confidentiality and bides by the standards and ethics of the Nova Scotia College of Physiotherapists. Your information will be accessed only by those team members involved in your care or in billing for services rendered. We will use reasonable security safeguards to protect your personal information against such risk as loss, theft, or unauthorized access.

Retention

We will keep personal information only as long as it remains necessary or relevant for the identified purposes, as required by normal business practices, or as required by law.

Disclosure

As a general rule, we only disclose information to third parties as instructed in writing by our clients. Circumstances of disclosure without consent are only those as required by law, including review by professional regulatory bodies.

I authorize One to One Wellness Centre to collect and store my information as outlined above. I authorize the release of information pertaining to evaluation, program, and progress to my medical doctor or other appointed professionals.

_____ Signature _____ Date