



Marda Loop Naturopathic and Wellness Clinic

Lavanya Kalathil Osteo/Massage B.Kin., RMT

Date _____

Name _____

Address _____

City _____ Postal Code _____

Best phone number to reach you at _____ (h) (c) (b)

Alternate phone number (optional) _____ (h) (c) (b)

E-mail _____

Date of Birth _____

Emergency Contact Name _____

Emergency Contact Phone Number _____

Emergency Contact Relation to You _____

Leisure Activities _____

How did you hear about me? _____

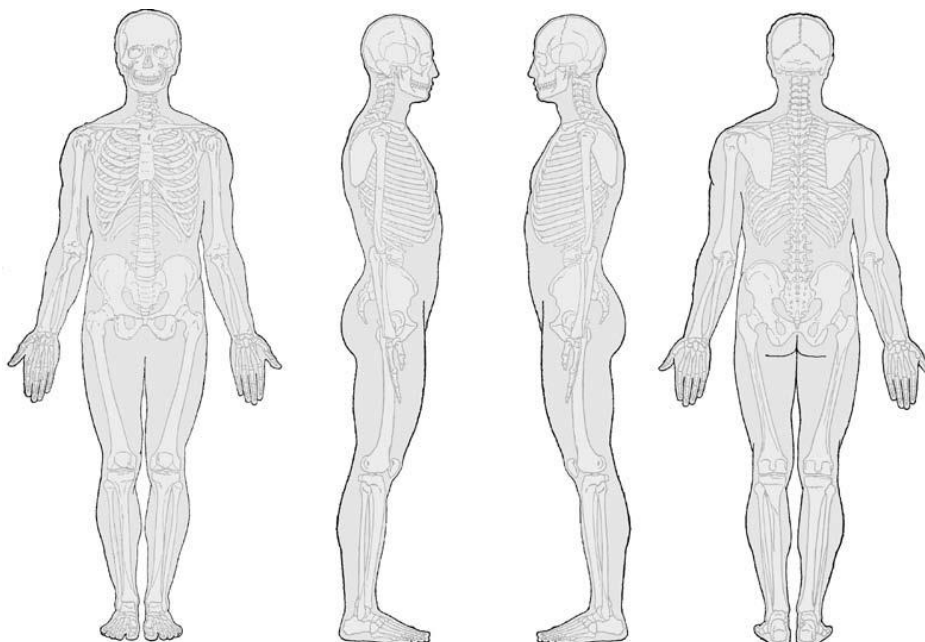
What are your main health concerns/reasons for visit, in order of importance?

List any surgeries, broken bones, major injuries/illness and year they occurred.

List any medications you are taking.

This is a confidential record of your medical history. Information contained in it will not be released to any person unless your authorization has been given to do so.

Please mark areas of pain, stiffness or discomfort on the diagram below:



Consent to Treat:

I have informed Lavanya of all known physical and medical conditions and will provide updated information if my health condition is to change in the future.

I am aware that along with the many benefits of treatment, there is also a small risk of injury associated with treatment. I will discuss these benefits and risks as well as the nature of the treatment and the conditions that will be addressed with Lavanya. I will be given the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by Lavanya and intend this consent to apply to all my present and future care with Lavanya.

Cancellation Policy:

In the event that I cannot keep my scheduled appointment, I agree to contact Lavanya at least 24 hours prior to my appointment time.

I am aware that when I book an appointment, that time is set-aside for me. I understand that missed appointments impact not only myself and Lavanya, but also other clients who may have needed that time. Because of this, if I do not attend an appointment and have not given the required notice, I agree to pay 50% of the cost of treatment as a cancellation fee.

Patient Signature (or legal guardian):

Date:

This is a confidential record of your medical history. Information contained in it will not be released to any person unless your authorization has been given to do so.