Visionary Health Medical Educational Clinic (VHMEC)
5359 Dundas St West Unit 108, Toronto, ON M9B1B1 647-478-9029 FAX: 647-557-3323
vhmec108@gmail.com info@vhmec.com www.vhmec.com

Occupational Therapy, Bowen Therapy Intake Form

First Name: _____ Last Name: _____

Date of Birth (MM/DD/YYYY): _____ Address: _____

City:_____ Postal Code:_____ Phone: _____ Cell: _____

Emergency Contact. _____

Email: _____ Occupation: _____

Family Doctor (Name & Contact):_____

How did you hear of Visionary Health? _____

Please list your health concerns: _____

Are you currently being treated by any other physician(s) or healthcare practitioners, please list?

_____

List all current medications: _____

Early Personal History:

Birth:_____

Childhood Traumas/(Any) Behaviour issues: _____

Memories that standout: _____

Family Circumstances (growing up years):
Parental and/or sibling relationships: _____

Family dynamics (mental health/medical health/addictions):_____

Medical History:

a) Surgery(s): _____ Month/Year: _____

b) Hospitalization: _____ Month/Year: _____

c) Illnesses/injuries/traumas (MVA, falls): _____

_____

How often do you use the following?

Alcohol: _____/day_____/week_____/month Recreational drugs: _____

Caffeine: _____/day_____/week_____/month Sugars: _____/day_____/week_____/month

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Education History :

List any and all educational experiences from past to present and highest level of completion:

Employment History:

List any and all occupational experiences from past to present

Past:

Present:

Relationship History (please circle):

Single: Yes No Details: _____

Married: Yes No Details: _____

Divorced: Yes No Details: _____

Children: Yes No How many? _____ Gender/Age(s) _____

Describe current relationship (s) with friends & significant others:

_____

Leisure Activities: _____

Spiritual Practice: _____

Describe the conditions in your life that is of greatest concern (seeking therapy):

_____

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INFORMED CONSENT- Occupational Therapy, Bowen Therapy

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended treatments and procedures to be used so that you make an informed decision whether or not to undergo the recommended procedure(s) after knowing the benefits and risks involved. This document is not meant to alarm you; it is simply to inform you that you may give or withhold your consent to treatment.
If you refuse any special procedure this will not affect your receiving other care or future treatments.

- I voluntarily request Hanh Bui to examine me. I understand that the course of care therapy may include the use of multiple modalities of OT done by Hanh Bui at the 5359 Dundas St West Unit 108, Toronto, Ontario, M9B 1B1.
- I understand that my verbal consent to a specific treatment and my willing participation in receiving these therapies after explanation of benefits and risks is sufficient to indicate my consent to receive treatment.
- I waive the option of signing consent to treat for each and every special procedure at each treatment date.
- I understand that I am free to pursue other medical opinions and treatments including conventional medical care at any time.
- I understand that I have the right and the opportunity to ask questions about my condition, discuss OT, naturopathic and conventional options at any time.
- I understand there may be complications and risks related to the recommended procedure(s) and that I may request additional information regarding complications and risks (side effects) and refuse any specific treatment at any time.
- I understand that there is payment for today's treatment, and subsequent follow-ups, at the time of service accordingly to the fee schedule.
- I understand that a phone consultation fee may apply.
- A Missed Appointment Fee of $50 will be charged to your credit card for any missed appointments or cancellations within 24 hours of the appointment. All outstanding invoices will need to be paid before the appointment.
- I understand that no warranty or guarantee regarding a promise of cure as a result of care is provided for any condition.
- I understand that a record will be kept of the health services provided to me and will be kept confidential.
- I give consent and authorize Visionary Health Medical Educational Clinic Practitioners to be contacted in the near future, for continued treatment.
- I understand that in the event there is a chance that media, audio or visual or published information could happen, all of which I am consenting that Visionary Health be able to use all various forms of social media.
- I authorize Visionary Health Medical Educational Clinic team to contact me for educational events, promotions, incentives, newsletters, engagements or information regarding of any health benefit.
- I certify that I have read this form or have had it read to me, and that I understand its content and meaning. I have sufficient information to give this informed consent.

Patient Name (please print):_____

Patient Signature:_____Date:_____