

HEALTH HISTORY FORM

How did you hear about our clinic?

Yellow Pages _____ Website _____ Our sign _____ Facebook _____ Other? _____

Family/Friend/Co-Worker _____ WHO? _____

Permission to acknowledge the person who referred you _____ (Initials)

Name: _____ Date: _____

Address: _____ Telephone:(Home) _____

City: _____ Prov: _____ Postal Code: _____ (Cell) _____

(Work) _____

Occupation: _____ Company: _____

Email Address: _____ Date of Birth(mm/dd/yy) _____

Emergency Contact: _____ Telephone: _____

Do you have Extended Health Care Insurance Coverage for Massage Therapy/Acupuncture/TCM? Yes No

Doctor's Name: _____ Telephone #: _____

Permission to consult with your Doctor: Yes No Initials: _____

Primary Complaint? _____ Aggravates/Relieves? _____

Have you seen a Doctor for this problem? Yes No When? _____

Overall, how is your general health? _____

Please indicate conditions you are experiencing or have experienced:

Respiratory

- Chronic Cough
- Shortness of Breath
- Sinus Problems
- Emphysema
- Asthma
- Allergies
- Other _____

Cardiovascular

- High/Low Blood Pressure
- Blood Clots
- Heart Disease/Heart Failure
- Myocardial Infarction
- Stroke/CVA
- Pacemaker** or similar device
- Other _____

Digestive

- Constipation/Diarrhea
- Gas/Bloating
- IBS
- Other _____

Nervous System

- Herpes/Shingles
- Numbness/Tingling
- Where? _____
- Chronic Pain
- Loss of Sensation
- Where? _____
- Other _____

Musculo-Skeletal

- Bone or Joint Disease
- Arthritis-Type _____
- Family Hx: _____
- Tendonitis
- Bursitis
- Sprains/Strains
- Low back/Hip/Leg pain
- Neck/Shoulder/Arm pain
- Jaw Pain/TMJ
- Other: _____

Reproductive

- Pregnant
- Due Date: _____
- Gynaecological: _____

Infections:

- Allergies- _____
- TB
- HIV/AIDS
- Other: _____
- Eczema/Psoriasis

Skin

- Bruise Easily
- Allergy to creams/lotions
- Athletes Foot
- Warts
- CFS/Fibromyalgia
- Other: _____
- Cancer- _____

Other

- Hepatitis
- Depression
- Diabetes-Type _____
- Vision/Hearing Loss
- Headaches/Migraines
- Epilepsy
- Kidney Disease _____
- Other: _____

Please turn over and complete other side⇒

Current Medications, Vitamins, Herbal Remedies & Conditions they treat:

Name: _____ Condition: _____
Name: _____ Condition: _____
Name: _____ Condition: _____
Name: _____ Condition: _____

Surgeries and Approximate Date:

Surgery: _____ Date: _____
Surgery: _____ Date: _____
Surgery: _____ Date: _____

Motor Vehicle Accidents and Date

Accident & Injuries: _____ Date: _____
Accident & Injuries: _____ Date: _____

Other Accidents and Injuries: _____ Date: _____

Presence of Internal Pins, Wires, Artificial Joints, Special Equipment, Etc.: _____

Other Therapies (Massage Therapy, Chiropractic, Physiotherapy etc.): _____

Do you have any other conditions not listed or is there anything about yourself you feel would be important for your Therapist to know: _____

Please check the body parts you consent to be treated:

Head/Face___ Neck___ Shoulders/Arms___ Hips___ Legs___ Buttocks___ Abdomen___ Inner Thigh___

Consent Form:

It is important that you fill out this health history form to ensure that it is safe for you to receive treatment. If your health status changes, please notify your therapist before your next treatment. All information gathered will be kept confidential except as required by law or to facilitate an assessment or treatment. Written authorization from you will be required before any information is released.

I agree to communicate with my therapist at any time if I have questions, if I feel uncomfortable, or if I feel my well-being is being compromised. I will give consent to my massage therapist to treat only on the areas of my body we discussed in the treatment plan. This may include sensitive areas such as gluteal/buttocks, breast/chest wall and upper inner thigh, if necessary. **Initials** _____

I am aware that I may remove only the clothing that I am comfortable removing. I know that I have the right to stop or modify the treatment at any time. It is my choice to receive massage therapy. I understand that Registered Massage Therapists do not diagnose illness, disease or any mental or physical disorder; nor do they prescribe medical treatment or pharmaceuticals. **Initials** _____

Cancellation Policy: There is a \$25.00 charge for the first missed appointment, or appointments cancelled with less than 24 hrs notice. There will be a full treatment charge for the 2nd and subsequent missed appointments. The 30-75 min. time slot is reserved specifically for you. If you are unable to keep your appointment please notify the office at least 24 hrs before your appointment to enable others to attend a treatment. If you are receiving treatment resulting from an automobile accident that is covered by an insurance claim, any missed appointments will be billed to you personally.

Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____
(if under 16 years of age)

Permission Form:

I, _____ give permission for the clinic of **Chippawa Therapeutics** to send informational material via mail or email. Personal Information collected by the clinic will not be used for any other purposes. Yes No

My email address is: _____

Signature: _____ Date: _____

For office use only:

History: _____

Update 1: _____ Update 2: _____ Update 3: _____