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CHIROPRACTIC HEALTH & WELLNESS

Health History Form

The information requested 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.

Name: _____ Phone #: _____
Address: _____
Occupation: _____ Date of Birth: _____
Have you received massage therapy before? ☐ Yes ☐ No
Did a health practitioner refer you for massage therapy? ☐ Yes ☐ No
If yes, please provide their name and address:
_____
_____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular:
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chronic congestive heart failure
- ☐ heart attack
- ☐ phlebitis / varicose veins
- ☐ stroke / CVA
- ☐ pacemaker or similar device
- ☐ heart disease

Is there a family history of any of the above? ☐ Yes ☐ No

Respiratory:
- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema

Is there a family history of any of the above? ☐ Yes ☐ No

Infections:
- ☐ hepatitis
- ☐ skin conditions
- ☐ TB
- ☐ HIV
- ☐ herpes

Is there a family history of any of the above?
☐ Yes ☐ No

Other Conditions:
- ☐ loss of sensation, where?
  _____
- ☐ diabetes, onset: _____
- ☐ allergies / hypersensitivity to what?
  _____
  type of reaction: _____
- ☐ epilepsy
- ☐ cancer, where?
  _____
- ☐ skin conditions, what? _____
- ☐ arthritis

Is there a family history of arthritis?
☐ Yes ☐ No

Head/Neck:
- ☐ history of headaches
- ☐ history of migraines
- ☐ vision problems
- ☐ vision loss
- ☐ ear problems
- ☐ hearing loss

Women:
- ☐ pregnant, due: _____
- ☐ gynaecological conditions, what?
  _____

Overall, how is your general health?
_____
Primary Care Physician:
_____
Address:
_____
_____
_____

Current Medications:
_____
condition it treats:
_____
Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No
If yes, for what? _____
Surgery - date: _____
nature: _____
Injury - date _____
nature: _____

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) ☐ Yes ☐ No
Do you have any internal pins, wires, artificial joints or special equipment? ☐ Yes ☐ No
what? _____
where? _____
What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort.
_____

Notes:

Date of Initial Health History:
_____
Update 1: _____
Update 2: _____
Update 3: _____
Update 4: _____

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MASSAGE THERAPY CONSENT FORM

* In keeping with the Health Care Consent Act (1996), it is my choice to receive massage therapy.

* I understand that an assessment by the massage therapist is required to determine the best course of treatment.

* I am aware that all information provided is private and confidential and will not be released without my written consent.

* I agree to communicate with my massage therapist at any time if I have questions, if I feel uncomfortable, or if I feel my well being is being compromised.

* I will consent to the massage therapist working only on those areas of my body that I am comfortable with.

* I am aware that I may change or terminate the treatment at any time at my discretion.

* I understand and am aware of the posted fees and cancellation policy.

* I am aware of the possible side effects from a massage treatment such as temporary muscular discomfort (24-48 hrs post treatment), possible bruising, and possible temporary dizziness.

* I understand the therapist will recommend remedial exercises and home care.

FEE SCHEDULE (includes HST)

90 Minute Massage Therapy ----------$120.00

60 Minute Massage Therapy ----------$82.00

45 Minute Massage Therapy ----------$65.00

30 Minute Massage Therapy ----------$50.00

CANCELLATION POLICY

In order that appointments remain available to all clients, 24 hour notice is required for changes or cancellations. The amount of $45 will be charged in the event of late cancellations or missed appointments. Thank you in advance for your co-operation.
By signing below, I understand and agree to all of the information listed above.

Client Signature_____ Date_____