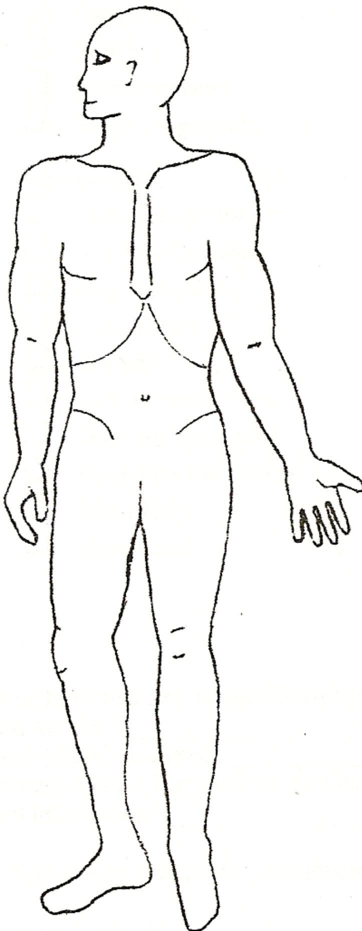
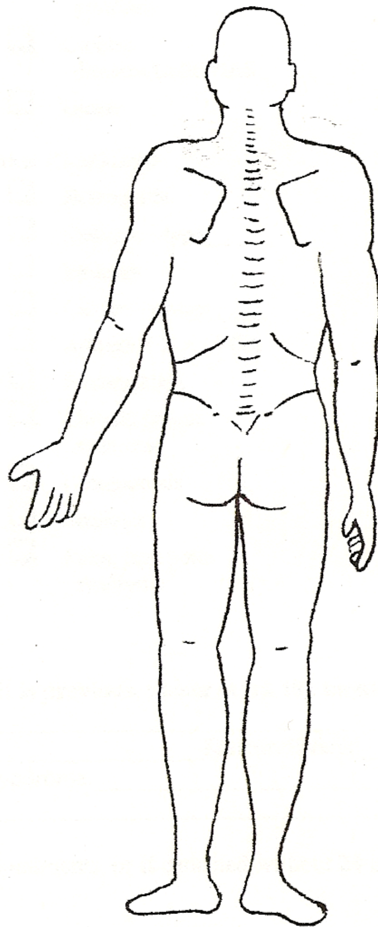
Massage Therapy
Health History Form:

Name:____ Date:______________________________
Address: ____
City ______________________ Province ____________ Postal Code: ________________
Telephone: Home: (_____)______________ Business:(____)______________Cell (____)_____________
Date of Birth: ________________ (DD/MM/YY) Occupation: ____________________________________
Doctor's Name: __________________________________ Address: ________________________________
Other Health Practitioner (s): ____
Have you received Massage Therapy before? ☐Yes ☐No
Main Reason For Coming: ____
What have you tried for relief? Heat___ Cold ____ Exercise ___ Other ___________________________
How were you referred to this Clinic? ____
Email Address:____
Please check this box if you would like to receive a monthly newsletter: ☐

Please indicate on the picture where you feel pain:
'S' = Stiffness 'X' = Pain 'N' = Numbness and/or tingling

Which areas provide discomfort or pain?

- ☐ Neck
- ☐ Upper Back
- ☐ Mid Back
- ☐ Lower Back
- ☐ Arm *(circle if right, left or both)*
  - Right Left Both
- ☐ Shoulder/Elbow/Wrist *(circle if right, left or both)*
  - Right Left Both
- ☐ Leg *(circle if right, left or both)*
  - Right Left Both
- ☐ Hip/Knee/Ankle *(circle if right, left or both)*
  - Right Left Both
- ☐ Other _____________

Please complete the reverse side of this form:

A4-550 Parkside Drive, Waterloo, ON N2L 5V4 519-746-3838

Please check the box if it currently or previously applies to you:

Head/Neck:
- ❑ Headaches
- ❑ Migraines ( )aura
- ❑ Vision/hearing problems
- ❑ Vision/hearing loss
- ❑ Earaches
- ❑ Herniated disk

Skin:
- ❑ Skin conditions (oily, dry, other)
- ❑ Bruise easily
- ❑ Plantar warts
- ❑ Rashes
- ❑ Loss of sensation
- ❑ Eczema or psoriasis

Cardiovascular:
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ Heart disease
- ❑ Phlebitis
- ❑ Varicose veins
- ❑ Deep vein thrombosis
- ❑ Congestive heart failure
- ❑ Stroke/CVA
- ❑ Heart Attack

Respiratory:
- ❑ Asthma
- ❑ Chronic Cough
- ❑ Shortness of breath
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Allergies

Digestive/Urinary:
- ❑ Constipation/Diarrhea
- ❑ Liver/gall bladder problems
- ❑ Kidney/bladder problems
- ❑ Crohnes diseases/Colitis/IBS
- ❑ Ulcers

Other Conditions:
- ❑ Hemophilia
- ❑ Diabetes – type______
- ❑ Epilepsy
- ❑ Cancer – where:_____
- ❑ Arthritis ( )RA ( ) OA
- ❑ Family History of Arthritis
- ❑ Fibromyalgia
- ❑ Chronic fatigue syndrome
- ❑ Osteoporosis
- ❑ Scoliosis
- ❑ Polio, post polio syndrome

Infectious Conditions:
- ❑ Tuberculosis
- ❑ AIDS/HIV
- ❑ Hepatitis: type ________
- ❑ Herpes
- ❑ Infectious Skin Conditions

Female:
- ❑ Menstrual problems

Heavy ___ Scant ____ Pain___
- ❑ Pregnancy

Due: ______
- ❑ Menopausal problems

Surgical Procedures:
- ❑ Pins/wires
- ❑ Artificial joints/limbs
- ❑ Other surgery

____

____

Medications:
What? ___________________
How Long? ________________
Condition it treats?

____

____

____

Do you have or have had any of the following? If it is previous, please mark the month and year:

Motor Vehicle Accident:____

Muscle/Ligament Sprain or Strain: ___________________ Fracture/Break:___________________

Tendonitis/Bursitis/Carpel Tunnel/Thoracic Outlet Syndrome:_______________________________

Any additional information?:____

____

Initial:______ Date: ______ Initial:______ Date: ______ Initial:______ Date: ______

Initial:______ Date: ______ Initial:______ Date: ______ Initial:______ Date: ______

Initial:______ Date: ______ Initial:______ Date: ______ Initial:______ Date: ______

Patient Consent to Treatment:

I understand that I have the right to ask questions about my treatment. If at any time I feel uncomfortable, I can ask the Therapist to stop or to clarify anything regarding the treatment. I am aware that Waterloo North Chiropractic & Massage is keeping the personal information outlined for the reasons disclosed. I have been informed that my file may be examined in a peer review to ensure quality of care I receive. Finally, I am aware that the members of staff at Waterloo North Chiropractic & Massage may access this information. I give my consent for this information to be collected and disclosed as outlined to me.

Patient Signature: ______________________________________Date:________________________

Office Policies:

1. You will receive treatment at this clinic with the understanding that massage therapy is a regulated health profession under the RHPA (Registered Health Professionals Act), and, as such, is bound by that act.
2. You understand that the therapist reserves the right to decide which cases fall outside the scope of practice. You may be referred to another practitioner, including another massage therapist, a chiropractor, a medical doctor, an osteopath, a physiotherapist, or a naturopath as your condition warrants and/or is in your best interest. This referral is based upon the information revealed in your health history, physical assessment, and discussion between the therapist and yourself.
3. You are accepting this treatment of your own free will and, therefore, have the right to terminate treatment at any time.
4. You understand that the ultimate responsibility of your healthcare is your own and that we are here to support you in this goal. We reserve the right to discontinue treatment where it is apparent that your expectations and the care provided are not in agreement.
5. You understand that all fees for treatment are payable when service is rendered. Payments can be made by cash, debit, Mastercard, and Visa. We do not provide direct-billing for extended health insurance; therefore, it is your responsibility to pay the fees directly to the provider and seek reimbursement for your claim using the provided statement of paid services.
6. You understand that we reserve the right, after ninety (90) days, to forward any unpaid balance to a collection service. By signing below, you agree to this policy and also to the release of any personal information that will enable this process, ie. Name, address, phone number(s), and any other possible contact information.
7. **You understand that you must provide a minimum of 24 hours' notice to cancel or change an appointment.** Failure to abide by this policy will result in a charge, as outlined below, being applied to your account, without exception. Missed or late cancellation fees are as follows:

30 min. appointment:	$25	60 min. appointment:	$45
45 min. appointment:	$35	90 min. appointment:	$60

8. You understand the importance of arriving on time for your scheduled appointment. No time extensions will be granted and the amount of time you are late by will be subtracted from your treatment time, while you will still be charge the full fee for your scheduled length of appointment.

I have read, understood, and acknowledged all statements in the above office policies.

Patient Signature: ______________________________________Date:________________________

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