Massage Therapy
Health History Form

Please take a moment to fill out this form before your visit. All information is kept completely confidential.

Name: _____ **Date:** _____

Birth Date (DD/MM/YY): _____

Address: _____

City: _____ **Postal Code:** _____

Email: _____

Telephone: (H) _____ **(C)** _____ **(W)** _____

Emergency Contact: _____ **Telephone:** _____

Family Doctor: _____ **Telephone:** _____

Other Health Care Practitioner(s): _____

Occupation: _____

How were you referred to this clinic? _____

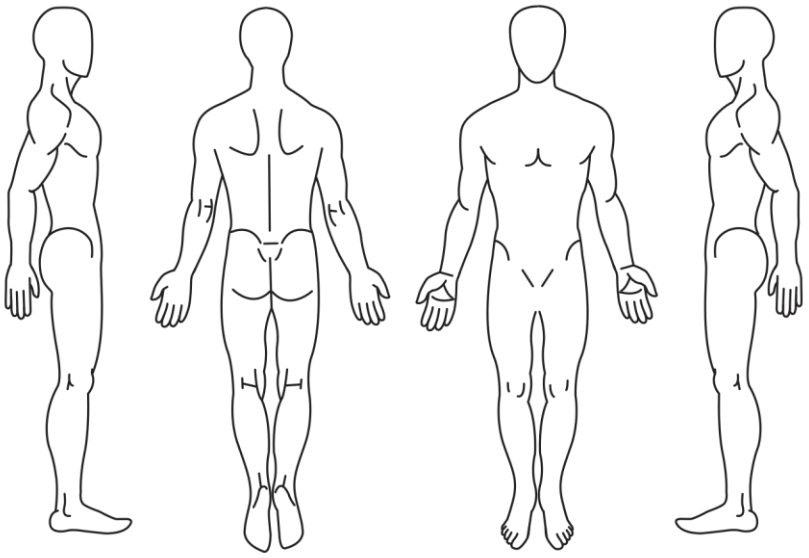
Have you received Massage Therapy before? _____

What is your primary reason for coming? _____

_____

Please indicate on the pictures where you feel pain:

S = stiffness X = pain N = numbness and/or tingling



Which areas provide discomfort or pain?

- ❑ Neck
- ❑ Upper Back
- ❑ Mid Back
- ❑ Low Back
- ❑ Arm (circle: Right Left Both)
- ❑ Leg (circle: Right Left Both)
- ❑ Hip (circle: Right Left Both)
- ❑ Knee (circle: Right Left Both)
- ❑ Ankle (circle: Right Left Both)
- ❑ Other: _____

What have you tried for relief?

Heat ____ Cold ____ Exercise _____ Other _____

What other therapies have you tried?

❑ Nothing thus far ❑ Massage Therapy ❑ Chiropractic ❑ Physiotherapy ❑ Osteopathy

❑ Naturopathy ❑ Reflexology ❑ Other: _____

If you currently have or previously had the following conditions, please check the boxes that apply:

Head/Neck
❑ Headaches
❑ Migraines
❑ Migraines with aura
❑ Vision/Hearing Problems
❑ Earaches
❑ Tinnitus
❑ Sinusitis
❑ Herniated Disk

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

Infectious Conditions
❑ Tuberculosis
❑ AIDS/HIV
❑ Hepatitis – Type: _____
❑ Herpes
❑ Infectious skin conditions Type: _____
❑ Other: _____

Respiratory
❑ Asthma
❑ Chronic cough
❑ Shortness of breath
❑ Bronchitis
❑ Emphysema
❑ Allergies

Digestive/Urinary
❑ Constipation/diarrhea
❑ Liver/gall bladder problems
❑ Kidney/bladder problems
❑ Chrohnes disease
❑ 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

Cardiovascular
❑ High blood pressure
❑ Low blood pressure
❑ Poor circulation
❑ Heart disease
❑ Phlebitis
❑ Varicose Veins
❑ Deep vein thrombosis
❑ Congestive heart failure
❑ Stroke/CVA
❑ Heart attack

Female
❑ Menstrual problems (circle) Heavy Scant Pain
❑ Pregnancy Due: _____
❑ Menopausal problems

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

Medications/Supplements

Name	**Condition(s) treated**	**How Long?**

Do you have or have you had any of the following? (If in the past, indicate the month and year)

❑ Motor Vehicle Accident: _____

❑ Muscle/Ligament sprain or strain: _____

❑ Fracture/Break: _____

❑ Tendonitis/Bursitis/Carpel Tunnel/Thoracic Outlet Syndrome: _____

Please provide any additional conditions/diagnoses/incidents not listed previously:

_____

❑ **I would like email notifications of new, cancelled and rescheduled appointments**

❑ Email 2 days before appointment ❑ Text Message (SMS) 3 hours before appointment

❑ **Yes, I would like to receive news and special promotions by email**

Accuracy of Information

❑ I certify that the above medical information is correct, to my knowledge.

Privacy and Sharing of Information
I authorize the clinic of Waterloo North Chiropractic & Massage and its associated health professionals to collect my personal and medical information as documented above.

❑ I agree

I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my written permission.

❑ I agree ❑ I disagree

Office and Cancellation Policies

1. You will receive treatment at this clinic with the understanding that massage therapy is a regulated health profession under the Registered Health Professionals Act (RHPA), 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 care 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 to forward any unpaid balance to a collection service after ninety (90) days. By signing below, you agree to this policy and also to the release of any personal information that will enable this process, i.e. name, address, phone number(s), and any other 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 being applied to your account, with no exception. Missed or late cancellation fees are as follows:

30 minute appointment - $30	45 minute appointment - $40
60 minute appointment - $50	75 minute appointment - $55
90 minute appointment - $60	

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

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

Patient Consent to Assessment/Treatment

❑ I understand that I have the right to ask questions about my assessment/treatment. If at anytime I feel uncomfortable, I can ask the therapist to stop, modify, or clarify anything regarding the assessment/treatment.

Patient Consent to Treatment of Sensitive Areas

I understand that should the massage therapist deem it clinically relevant, I voluntarily agree and grant my consent for the assessment and/or treatment of the following areas deemed as sensitive: a) Chest Wall muscles/Pectorals; b) Inner Thigh muscles; c) Buttocks/Gluteal muscles; and/or d) Breast tissues. I also fully understand it is within my right to ask questions, and ask to modify or stop the assessment/treatment at any time. I have been informed and understand: a) the nature of the assessment, including the clinical reason(s) for treatment of the area(s) listed above and the draping methods used; b) the expected benefits of the treatment as well as the potential side effects and risks of the treatment; c) subsequent Consent is voluntary and I understand that without this, the RMT may not be able to provide the requested assessment/treatment described above; and d) my Consent may be withdrawn at any time.

❑ I understand and voluntarily consent to the Assessment/Treatment of Sensitive Areas as stated.

❑ I understand and DO NOT consent to the Assessment/Treatment of Sensitive Areas as stated.

Patient Signature: _____ **Date:** _____