Health First Chiropractic and Massage Health History Form

Name: _____ D.O.B.: _____
Address: _____
Mobile Phone: _____ Home Phone: _____
Email: _____
Name & number in case of emergency: _____
Occupation: _____
How did you hear about us? _____

Please tick (x) all the conditions that apply now and put a **P** for past conditions:

□ Heart, Circulatory Problems	□ Cancer/Tumours	□ Vision Problems
□ High/Low Blood Pressure	□ Asthma	□ Hearing Problems
□ Varicose Veins	□ Difficulty Breathing	□ Fatigue
□ Blood Clots	□ Hernias	□ Depression
□ Phlebitis	□ Digestive Problems	□ Seizures
□ Infectious Disease	□ Osteoarthritis/Rheumatoid	□ Stroke
□ Rash, Tinea	□ Numbness/Tingling	□ Skin Disorders
□ Allergies	□ Muscle Injury/Pain	□ Pregnancy
□ Diabetes	□ Bone Injury/Pain	□ Headaches
□ Motor Vehicle Accident	□ Joint Injury/Pain	□ Migraines
□ Accident/Trauma	□ Chronic Pain	□ Memory Loss/Confusion
□ Broken Bones	□ Disc Problems	□ Prosthesis

Please, provide further details of any conditions you have indicated: _____
_____

Other medical conditions not listed (past/present): _____
_____

Are you currently on any medications? Yes □ No □ Details: _____
_____

Recent surgeries: None □ Details: _____

Name of your primary health care provider (doctor): _____

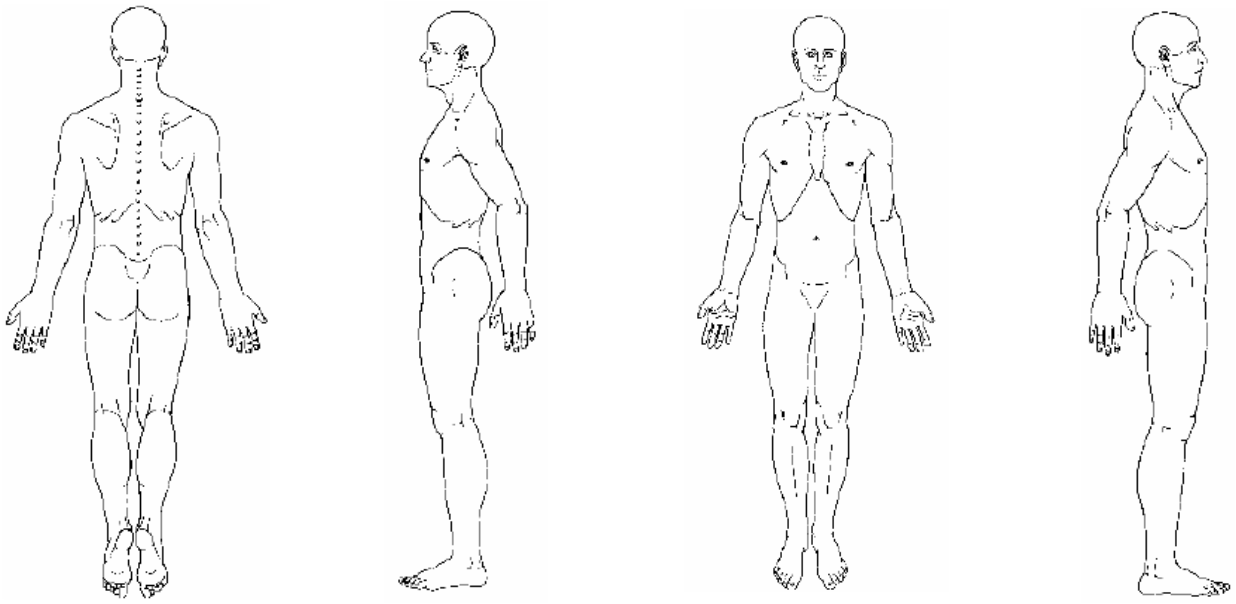
I give permission for my Remedial Therapist to consult with my doctor regarding my health and treatment if required Yes □ No □

Have you hade a Remedial Massage before? Yes □ No □
What are your current complaints of injuries? _____
_____
_____

Which of the following best describe what you are experiencing?

Pain	□	Mild	□	Getting worse	□	Increase with activity	□
Ache	□	Moderate	□	Staying the same	□	Reduces with activity	□
Tension	□	Disabling	□	Getting better	□	No change	□
Discomfort	□	Constant	□	Imbalance	□	Intermittent	□

On the diagram below identify where your current symptoms are by circling the area and marking it with a: **P** = Pain **S** = Muscle stiffness **JT** = Joint pain **N** = Numbness & tingling:



Notes: _____
_____
_____

Consent is required to massage each part of the body. Please, indicate which areas you would like to be included (**For relaxition massage clients only**):

□ Back □ Buttocks □ Legs □ Feet □ Arms □ Stomach □ Chest □ Face □ Head □ Neck

INFORMED CONSENT FOR MASSAGE THERAPY PLEASE READ CAREFULLY:

I understand that massage therapy is the manipulation of soft tissue and joints throughout the body. I understand the benefits and risks of massage therapy treatments. If the pressure is too deep or causes excessive pain, I will inform my therapist. I understand that only the body part being worked on will be uncovered, while the rest of my body will remain covered with the sheet at all times. I am aware that I do not have to remove any clothing that I am uncomfortable removing, but also know that massage therapy is most effective directly on the skin. If I am uncomfortable at any point or want the treatment to be altered in any way, I will inform my massage therapist. I have completed my health history form to the best of my knowledge and will continue to inform my massage therapist of any changes in my health or personal information. I understand that all fees for treatment are payable when service is rendered. Payments can be made by cash, debit, Visa or Mastercard. The therapist does not provide direct billing for extended health insurance. Fee Schedule (including HST): 30 min treatment: $65, 45 min treatment: $90, 60 min treatment: $110, 90 min treatment: $160. Massage Therapists as health professionals do not offer discounts, packages or incentives to use their services. Cancellation / No Show Policy We have a 24-hour cancellation policy. If you are unable to provide this notice, we will charge you $55 for the missed appointment if we are unable to fill the spot. We often have a waiting list and if given enough notice we can fill the appointment. If you have an emergency, please let us know so that we can treat your specific situation with personal attention. This cancellation policy is necessary for our small business to continue to serve our clients in need of treatment. **Please initial here indicating you have read and understand our cancellation policy. X_____

Signature: _____ Date: _____