Northern CHIROPRACTIC & WELLNESS CENTRE

"Taking care of your health naturally"

Health History:

Name: ______________________________ Phone: ______________________________
Address: ____
Occupation: ______________________________ Date of Birth (DD/MM/YY): ______________________________
Have you received Massage Therapy before? Yes ☐ No ☐ Email: ______________________________
Were you referred by another health care professional? Yes ☐ No ☐
If so, please provide their name and address: ______________________________

____

Please indicate conditions you currently have or have had in the past:

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 family history of any of the above?
Yes ☐ No ☐

Respiratory:
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

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

Infections:
- ☐ Hepatitis
- ☐ Skin Conditions
- ☐ TB
- ☐ HIV
- ☐ Herpes

Other Conditions:
- ☐ Loss of sensation, where? ______________________________
- ☐ Diabetes, onset: ______________
- ☐ Allergies/Hypersensitivity to what? ______________________________
  type of reaction: ______________
- ☐ Epilepsy
- ☐ Cancer, where? ______________________________
- ☐ Skin conditions, what? ______________________________
- ☐ Arthritis

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

Head/Neck:
- ☐ History of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Vision loss
- ☐ Ear problems
- ☐ Hearing loss

Women
- ☐ Pregnant, due: ______________
- ☐ Gynaecological condition, what? ______________

Overall, how is your general health?
____

Primary Care Physician:
____

Address:
____
____

Current Medications:
____
Condition is 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.
____
____
____

Massage Treatment / Assessment / Cancellation Policy Consent Form

I have been informed about the purpose of the assessment and about the related benefits of treatment, as well as the possible risks and side effects. I have had the opportunity to ask any questions regarding the assessment / treatment during the visit, as well as any alternatives. I understand that I can stop the assessment / treatment at any time.

It is important that you be punctual for your appointment so you may benefit from the full time slot reserved for your treatment. If you are unable to keep your appointment, please advise us 24 hours in advance to avoid a late cancellation fee of $25.00.

I, ______________________________, consent to the assessment / treatment / cancellation policy by an RMT of Northern Chiropractic & Wellness Centre.

______________________________ ______________________________
Signature of patient / parent / legal guardian Date