MASSAGE THERAPY

PATIENT HISTORY

Care Chiropractic Health & Rehab

Patient Information

Patient's Legal Name: _____ Preferred Name_____ Date: _____

Address: _____ City:_____ Postal Code: _____

Home #: _____ Work #: _____ Cell #: _____

Cell Provider (optional):_____ Email (optional): _____ **Your cell and email will not be shared with third parties & is used for appointment reminders. I understand that I can opt out at any time by informing CARE that I no longer wish to receive appointment reminders.*

Birth Date: D/ ___ M/ ____ Y/ _____ Age: ____ ☐ M ☐ F Married _____ Single _____

Occupation: _____ Medical Doctor: _____ Phone #: _____

In case of emergency, contact: _____ Phone: _____

Whom may we thank for referring you to our office? _____

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
- ❑ Dizziness/vertigo
- ❑ Seizures

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

_____

Head and Neck
- ❑ History of headaches
- ❑ History of migraines
- ❑ Vision problems
- ❑ Vision loss
- ❑ Ear problems
- ❑ Hearing loss

Women
- ❑ Pregnant

Due date: _____
- ❑ Previous pregnancy complications:

_____
- ❑ Menopausal complications:

_____
- ❑ Menstrual complications:

_____
- ❑ Gynecological Conditions:

_____

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

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

Skin Conditions
- ❑ Open sores
- ❑ Eczema
- ❑ Psoriasis
- ❑ Rash
- ❑ Warts

Muscle/Joint
- ❑ Neck
- ❑ Back (Lower)
- ❑ Back (Mid)
- ❑ Back (Upper)
- ❑ Shoulders
- ❑ Elbow
- ❑ Wrist/Hand
- ❑ Hip
- ❑ Knee
- ❑ Ankle/Foot
- ❑ Spine

Men
- ❑ Enlarged prostate
- ❑ Libido issues
- ❑ Other: _____

Digestive
- ❑ Constipation
- ❑ Crohn's Disease
- ❑ Colitis
- ❑ Irritable Bowel Syndrome
- ❑ Ulcers

Infectious Conditions
- ❑ Skin Conditions

_____
- ❑ Respiratory conditions

_____
- ❑ Hepatitis

Other
- ❑ Loss of sensation

Where: _____
- ❑ Diabetes

Onset: _____

Type: _____
- ❑ Allergies/Hypersensitivity

What? _____
- ❑ Epilepsy
- ❑ Cancer

Type: _____

Location: _____
- ❑ Arthritis

Is there a family history of arthritis?

❑ Yes ❑ No
- ❑ Hemophilia
- ❑ Fibromyalgia
- ❑ Chronic fatigue
- ❑ Scoliosis
- ❑ Polio/Post-polio
- ❑ Osteoporosis

Relevant History

2. Do you have any medical conditions not listed above? ❑ Yes ❑ No
If yes, please describe: _____
_____
_____

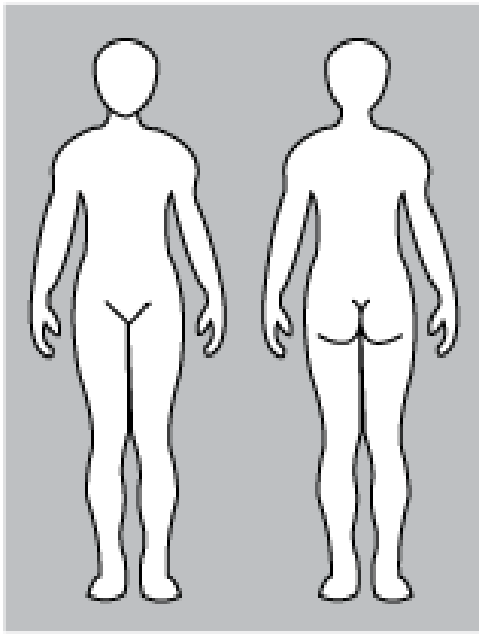
3. Do you have any internal wires, artificial joints, pacemakers or special equipment? ❑ Yes ❑ No

4. For what condition or reason are you seeking treatment today? _____
_____

5. Please mark the areas which are currently causing you symptoms of pain, stiffness, numbness or other forms of discomfort:

Please indicate by marking areas on the chart using the following symbols:

oooo	Pins and Needles
////	Stabbing
xxxx	Burning
+++	Aching
= = =	Numbness
▲▲▲	Stiffness



Using the scale to the right, place a vertical line (|) relative to your current pain or discomfort

No pain — Worst possible pain

6. Have you seen any other health care professional(s) for this condition or reason? ❑ Yes _____ ❑ No

7. Have you ever been involved in any motor vehicle accidents? ❑ Yes ❑ No Date: _____

8. Have you ever been involved in any other accidents? ❑ Yes ❑ No Date: _____

9. Have you ever been knocked unconscious? ❑ Yes ❑ No Date: _____

10. Briefly list any surgeries you have undergone, for what & when_____
_____
_____

11. Are you presently taking any prescribed medication(s)? ❑ Yes ❑ No
If yes, please list: _____
_____
_____
_____

12. Have you previously received massage therapy treatments? ❑ Yes ❑ At this clinic ❑ RMT ❑ Other_____ ❑ No

13. Please mark on the following scales the extent to which you are currently satisfied with the following:

(5 represents total satisfaction, 1 represents little or no satisfaction)

Physical Health & Fitness	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Mental & Emotional Happiness	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Energy Level	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Diet	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Ability to relax	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1

14. What do you hope to gain from your massage therapy treatment? _____

I acknowledge that the Massage Therapist is not a physician & does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailment that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge & understand that the Massage Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Massage Therapist & disclosed all medical conditions affecting me. It is my responsibility to keep the Massage Therapist updated on my medical history. The information I have provided is true & complete to the best of my knowledge.

Consent to the Collection, Use and Disclosure of Personal Health Information: Maintaining the protection of your personal health information is required by provincial and federal law. This information will be securely maintained in charts or electronically for a minimum of ten years past the last date of treatment. To access this information, the Clinic must receive your written consent to release this information to a designated individual or organization. You also understand that this information will be accessible to and shared amongst each of the health service providers within the clinic for the purposes of providing integrated, patient centered health services for:

- Chiropractic/Massage Therapy or other clinical services
- To obtain payment from a third-party insurance company for treatments provided, if applicable

I understand that I can withdraw my consent to collect, use and disclose my personal health information by providing written notice to the treating practitioner

Signature: _____Date: _____ Therapist Signature: _____

Parent/Guardian Signature: _____ Date: _____ Therapist Signature: _____

Care Chiropractic
Health & Rehab

Effective January 1, 2019 the Massage Therapy cancellation policy will be applied as follows:

Early notice of the need to cancel an appointment is required. This allows for the opportunity for other patients to book in to receive Massage Therapy care and for the Massage Therapist to plan their schedule accordingly.

Patients who cancel appointments within four (4) hours of the scheduled time will be billed at 50% of the rate of the applicable treatment.

Patients who no-show or fail to make it to an appointment will be billed at 100% of the rate of the applicable treatment.

Please note that insurance benefits do not cover cancellation or no-show fees. Motor Vehicle Accident patients – please note that cancellation or no-show fees are not covered under your protocol.

Print Name: _____

Signature: _____Date: _____ Therapist Signature:_____

Parent/Guardian Signature: _____Date: _____ Therapist Signature:_____