Superior Chiropractic

Date (YYY/MMM/DD): _______/________/________

Unit 4- 570 Red River Road
Thunder Bay, ON P7B 1H3
(807)345-6700

HEALTH HISTORY FORM

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes In the future, please let me know. All information gathered for this treatment is confidential unless allowed or required by law. Your written permission will be required to release information.

PERSONAL INFORMATION

NAME:_____________________________________ DATE OF BIRTH (YYYY/MMM/DD) _______/________/_______

HOME #:___________________________________ CELL #:______________________ WORK #:_____________________

ADDRESS:____

CITY:____ POSTAL CODE: ____

EMAIL ADDRESS:____

EMERGENCY CONTACT NAME & NUMBER: ____

CONSENT FOR CLINIC TO SEND EMAILS YES NO

WOULD YOU LIKE EMAIL REMINDERS FOR APPOINTMENTS? YES NO

OCCUPATION:____

REFERRED BY:____

HAVE YOU EVER EXPERIENCED MASSAGE THERAPY? YES NO

GENERAL HEALTH STATUS: POOR/FAIR/GOOD/EXCELLENT

DO YOU HAVE EXTENDED HEALTH BENEFITS? YES NO

PRIMARY PLAN ____

POLICY #__________________________________ ID# ____

POLICY MEMBER NAME ____

DATE OF BIRTH (YYYY/MMM/DD) _______/________/________

SECONDARY PLAN ____

POLICY #___________________________________ ID# ____

POLICY MEMBER NAME ____

DATE OF BIRTH (YYYY/MMM/DD) _______/________/_______

PLEASE CIRCLE ANY CONDITIONS YOU ARE EXPERIENCING, OR HAVE EXPERIENCED IN THE PAST:

RESPIRATORY	**NEUROLOGICAL**	**DIGESTIVE**	**CARDIOVASCULAR**	**OTHER CONDITIONS**
Chronic Cough	Loss of Sensation	Diarrhea	High Blood Pressure	Arthritis
Shortness of Breath	Numbness/Tingling	Constipation	Low Blood Pressure	Cancer
Bronchitis	Seizures	Crohn's Disease	Chronic Congestive Heart Failure	Diabetes: Onset___________
Asthma	Epilepsy	Colitis	Heart Attack	Headaches: ________________
Emphysema	Sciatica	Irritable Bowel	Phlebitis/ Varicose Veins	Skin Conditions: ________________
INFECTIONS:			Stroke/ CVA	Vision Problems
Hepatitis A,B,C,D			Heart Disease	Hearing Problems
Tuberculosis			Pacemaker/ Other Devices	Pregnancy **YES** **NO** If yes,
HIV/ AIDS				Due Date: (YYYY/MMM/DD) ______/_______/_______
Herpes				

Do you have any allergies? ____

Do you have any other medical conditions? (e.g. hemophilia, osteoporosis, fibromyalgia) Yes / No

Please describe ____

____

Do you have any internal pins, wires, artificial joints or special equipment? Yes / No

Please describe ____

____

Are you currently receiving treatment from another Health Care Professional? Yes / No

If yes, for what? ____

Primary Care Physician :____

Name of Chiropractor:____

CURRENT MEDICATIONS	**CONDITION IT TREATS**
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

INJURIES - TYPE AND LOCATION ON BODY	**Date: (YYYY/MMM/DD)**
______________________________________	_____/_____/_____
______________________________________	_____/_____/_____
______________________________________	_____/_____/_____

SURGERY – PROCEDURE AND LOCATION ON BODY	**Date: (YYYY/MMM/DD)**
______________________________________	_____/_____/_____
______________________________________	_____/_____/_____
______________________________________	_____/_____/_____

What is the reason you're seeking massage? ____

____

INFORMED CONSENT

- ✓ You, the client, have the right to accept or refuse any treatment to your body
- ✓ You have the right to refuse, modify, or terminate any treatment, or any aspect of any treatment, at any time, regardless of prior consent
- ✓ Only those areas being treated will be undraped. Being fully draped or fully clothed during the treatment is also an option
- ✓ If the RMT feels that referral to another Health Care Provider is necessary, this will be communicated to the client and done so only with proper consent
- ✓ The RMT has the right to deny treatment if there is reasonable cause. This therapeutic relationship is based on mutual respect and commitment.
- ✓ **Cancellation policy – 24 hours notice required or the FULL FEE of the appointment will be charged.**
- ✓ **I have discussed the treatment and/or treatment plan with DARREN TODD, RMT. During this discussion, the benefits, risks, fees, side effects, areas to be treated, positioning and types of draping to be used have been explained to me. I fully understand and provide consent to treatment(s).**

- ✓ **PATIENT SIGNATURE** ______________________________ **DATE** ______________