Superior Chiropractic

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

Date:_____

Updated: _____

Updated: _____

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 any information.

PERSONAL INFORMATION

NAME:_____ **HOME #:**_____

ADDRESS:_____ **CELL #:**_____

POSTAL CODE: _____ **EMAIL ADDRESS:**_____

DATE OF BIRTH (D/M/Y):_____ **CONSENT FOR CLINIC TO SEND EMAILS YES NO**

OCCUPATION:_____ **REFERRED BY:**_____

HAVE YOU EVER EXPERIENCED MASSAGE THERAPY? ____ GENERAL HEALTH STATUS: POOR/FAIR/EXCELLENT

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: Due:_____
HIV/ AIDS				
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**
_____	_____
_____	_____
_____	_____

SURGERY – PROCEDURE AND LOCATION ON BODY	**DATE**
_____	_____
_____	_____
_____	_____

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 _____**