Health History Form

Ajax Chiropractic & Wellness
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The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name_____Date (day/month/year)_____

Address: Number_____Street_____City_____Province_____ Postal Code_____

Phone #: Cell_____Home_____

Occupation: _____ Date of Birth (day/month/year)_____

Gender: **Male** **Female** identifies as(if applicable):_____

Referred by: _____(physician, internet, yellow pages, patient)

Email Address: _____

Do we have permission to contact you via email (circle one) **YES** **NO**

Have you received massage therapy before? (circle one) **YES** **NO**

Did a health care practitioner refer you for massage therapy? (circle one) **YES** **NO**

If yes, please provide your physicians name and address_____

Cardiovascular:
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart attack
- ☐ Phlebitis/varicose veins
- ☐ History of Stroke/CVA
- ☐ Pacemaker or similar device
- ☐ Heart Disease

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

Respiratory conditions
- ☐ Chronic cough
- ☐ Bronchitis
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Emphysema
- ☐ Sinus infection

Infectious conditions
- ☐ Hepatitis _____
- ☐ Infectious skin conditions
- ☐ Respiratory conditions – TB
- ☐ Herpes
- ☐ HIV

Other conditions
- ☐ Skin Conditions _____
- ☐ Allergies or hypersensitivity (anaphylaxis or skin irritation _____
- ☐ Loss of sensation, where? _____
- ☐ Diabetes onset:_____
- ☐ Cancer_____
- ☐ Epilepsy
- ☐ Arthritis RA/OA
- ☐ Fibromyalgia
- ☐ Digestive disorders _____
- ☐ Hernia_____
- ☐ Osteoporosis

Reproductive conditions
- ☐ Pregnant(due:_____)
- ☐ Gynecological conditions _____
- ☐ Menopause

Family history of:
- ☐ Respiratory difficulties
- ☐ Cardiovascular difficulties
- ☐ Cancer
- ☐ Arthritis

Soft tissue/joint discomfort and its nature (eg. Pain, tension, injury)
- ☐ Head _____
- ☐ Neck _____
- ☐ Low Back _____
- ☐ Mid Back _____
- ☐ Upper Back _____
- ☐ Shoulders L R _____
- ☐ Arms L R _____
- ☐ Legs L R _____
- ☐ Knees L R _____
- ☐ Others _____

Do you have any other medical conditions not listed above? _____

_____

Overall how is your general health?_____

Please list current medications and the conditions they treat: _____

_____

Please list all allergies_____

Are you currently receiving treatment from another health care professional? **YES** **NO**

If yes, for what? _____

Please list all surgeries (include date of injury and surgery)_____

Do you have any internal pins, wires, artificial joints or special equipment(please list type and location)?_____

_____

What is the reason you are seeking massage therapy? (please include the locations of tissue or joint discomfort)_____

_____

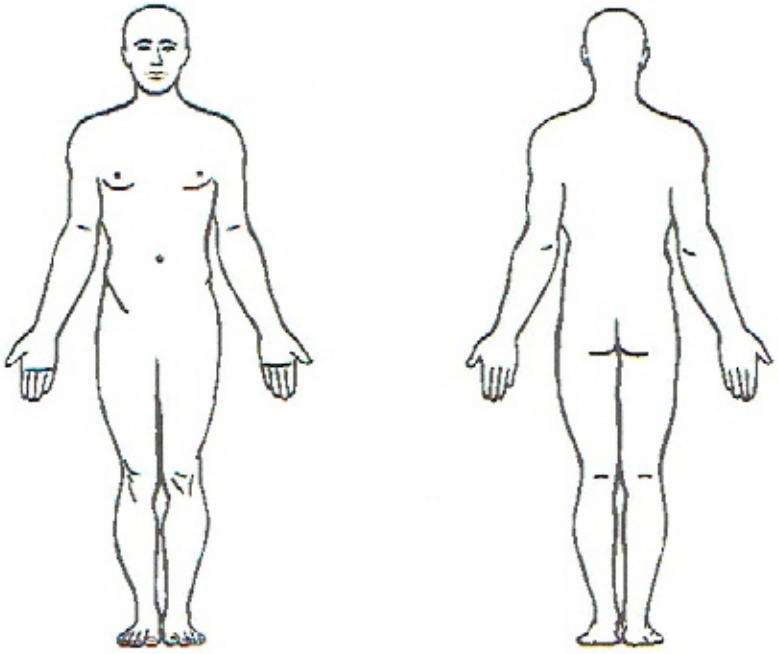
Please mark the areas of your body that you are currently feeling discomfort on the figure. (right)

Please circle a number from 1-10 to indicate what level of pain you are experiencing. (below)

1 2 3 4 5 6 7 8 9 10
(slight) (moderate) (severe)

Date of Initial Health History:_____
Update 1: _____
Update 2: _____
Update 3: _____

For office use only



Consent to Treatment

I acknowledge that my therapist has provided me with information relevant to treatment of the listed chief complaint(s). Alternative courses of treatment, where applicable, have been explained to me, as well as the risk of side effects (if any) of my therapists proposed treatment plan. I understand fully the consequences of having treatment or not having treatment. I also understand that at any time and upon informing my therapist of my decision, I may withdraw consent with the intent to alter or discontinue treatment. In compliance with the **Health Care Consent Act**, and of my own free will, I will provide my full, voluntary, and informed consent to treatment.

Patient Signature: _____ Date: _____

Office Policies

Massage treatments are to be paid in full. A receipt will be issued, and can be used to submit to your benefit company for reimbursement (if applicable).

When a treatment has been booked, we commit to reserving that time for you and in kind, require 24 hours notice for any cancellation, or a **$40 CANCELLATION FEE WILL BE CHARGED.**

I understand and agree to be responsible for any missed appointments without 24 hours notice.

Patient Signature: _____ Date: _____