NORFOLK CHIROPRACTIC WELLNESS CENTRE

Massage Therapy Health History Form

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The information requested below will assist us in treating you safely and effectively. Please note that all information provided below will be kept confidentially unless allowed or requested by law (your written permission will be required). If at any time you have any questions regarding your visit, please feel free to ask!

Name:_____ Phone: (H) _____ (W) _____
E-mail: _____ Cell phone: _____ Today's Date: _____
Address: _____ City: _____ P.C. _____
Occupation: _____ Date of Birth: _____
Your Primary Care Physician - Name & address:_____
Where did you hear about our clinic?_____ Have you had a massage before? _ YES _ NO
What brings you in for a massage? _____
Overall, how is your general health? _____

Please indicate conditions you are experiencing or have experienced:

CARDIOVASCULAR
Current/Previous

_ _ High Blood Pressure
_ _ Low blood Pressure
_ _ Chronic Congestive Heart Failure
_ _ Heart Attack
_ _ Phlebitis/Varicose Veins
_ _ Stroke/CVA
_ _ Pacemaker or similar device
_ _ Poor Circulation
_ _ Heart disease

RESPIRATORY
Current/Previous

_ _ Chronic Cough
_ _ Shortness of Breath
_ _ Bronchitis
_ _ Asthma
_ _ Emphysema
_ _ Breathing Problems

HEAD/NECK
Current/Previous

_ _ Headaches: Type: _____
_ _ Vision Problems/Loss
_ _ Earaches
_ _ Vertigo/Dizzyness
_ _ TMJ Dysfunction

WOMEN
Current/Previous

_ _ Menstrual Problems
_ _ Gynecological Conditions: What? _____

Pregnant? _ YES _ NO
Due Date: _____
Number of Children: _____

INFECTIONS
Current/Previous

_ _ Hepatitis
_ _ Herpes
_ _ Skin Conditions
_ _ TB
_ _ HIV/AIDS

OTHER HEALTH CARE
Current/Previous

_ _ Massage Therapy
_ _ Chiropractic
_ _ Physiotherapy
_ _ Psychotherapy
_ _ Regular Exercise

CURRENT MEDICATIONS

Medication: _____
Condition:_____

Medication: _____
Condition:_____

Medication: _____
Condition:_____

OTHER CONDITIONS
Current/Previous

_ _ Liver
_ _ Gall Bladder
_ _ Kidney/Bladder
_ _ Diabetes - Onset _____
_ _ Insomnia
_ _ Cancer - Where? _____
_ _ Epilepsy
_ _ Constipation
_ _ Digestive Difficulties
_ _ Allergies/hypersensitivity What? _____
_ _ Loss of Sensation Where? _____
_ _ Arthritis, or family history of? 1 YES 1 NO Affected Areas:_____
_ _ Any internal wires, pins, artificial joints? Where? _____

PREVIOUS INJURIES/SURGERIES

Nature:_____
Date: _____

Nature:_____
Date: _____

Nature:_____
Date: _____

Please turn over and fill out back of form ....

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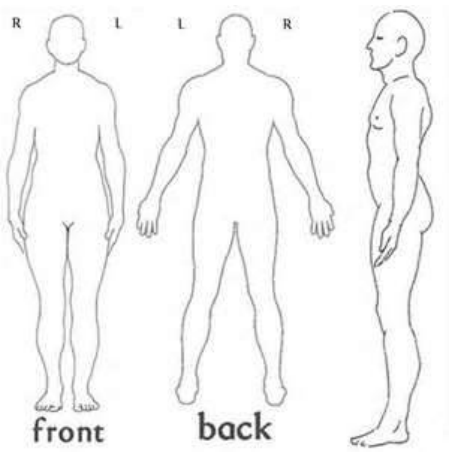
Please mark an "X" on the picture where you feel discomfort.



Please check off where you feel discomfort.

_ Neck	_ Upper Back	_ Lower Back	_ Mid Back
_ Arms	_ Hands	_ Hips	_ Thighs
_ Lower Legs	_ Knees	_ Ankles	_ Feet
_ Chest	_ Abdomen	_ Head	_ Gluteals/Buttocks

_ Other: _____

How long have you experienced it?

_____

What tends to relieve or aggravate your pain?

_____

Informed Consent

I understand that the purpose of massage therapy is to restore and maintain the integrity of the musculo-skeletel system. I understand that massage therapy is a hands-on healthcare discipline that will require the therapist to place his/her hands on those parts of the body that are involved in the cause of my symptoms. I am aware that my therapist is a Registered Health Care Professional and has the right to discontinue the treatment at their discretion.

I understand that I have complete control of my own treatment and the right to change/alter or discontinue the treatment at any time should I feel uncomfortable.

I understand that massage therapists do not diagnose illnesses, disease or any physical or mental disorders; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal manipulations.

I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I further understand that in the practice of massage therapy there is the potential for mild side effects, including, but not limited to muscle soreness/point tenderness in the areas worked (lasting up to 24 - 48 hours), mild bruising, headache and possibly feeling lightheaded. Following the treatment, feelings of fatigue are common. Cold packs on achy areas (10 min on, 10 min off) will help minimize any discomfort. Please feel free to call us any time at the clinic if you have any questions or concerns.

Fee is due at the time of treatment; cash, cheques, interac, Visa and Mastercard are accepted.

I _____ have read and acknowledge all the above information and give my consent for massage treatment/assessment.
(please print name)

Signature: _____ **Date:** _____
(if patient is a minor - signature of parent/guardian)

_____ **I understand that without 24 hours notice, I will be billed full price for my missed appointment.**
(patient initials)