Back to Health WELLNESS

The information on this form is confidential and will be used for the therapist to evaluate and assess your condition and physical basis to determine a course of treatment. An accurate health history is important to ensure that it is safe for you to receive massage treatment. If your health status changes in the future please let us know.

We regret we must charge a missed appointment fee of $25.00 for an appointment cancelled with less than 24 hours notice.

Name: _____ Telephone: Work _____ Home _____

Address: _____ Postal Code _____

Date of Birth: _____ Gender: □ Male □ Female Occupation: _____

Who to contact in case of an emergency: _____ Relation: _____

Contact Number: _____

Name of Physician: _____ Physician's Number: _____

Are you currently receiving treatment from another Health Care Practitioner? If so, please indicate why: _____

_____

Where did you hear about our Clinic?

□ Article □ Name of friend _____
□ Website □ Name of Doctor _____
□ Other _____

Can you please list any previous injuries, surgeries serious illness or allergies: _____

_____

_____

Do you have any of the following?

□ Wires □ Artificial Joints
□ Internal Pins □ Wheelchair
□ Walker □ Cane
□ Other _____

Current Medication(s)

Name:	***For what Condition:***

Is this your first massage treatment? □ No □ Yes

Back to Health WELLNESS

Please check or fill in the appropriate information:

What is your primary complaint? _____

Head / Neck
- □ Headaches
- □ Migraines
- □ Sinus Problems
- □ Vision Problems
- □ Hearing Loss

Muscles / Joints
- □ Neck
- □ Upper Back
- □ Mid Back
- □ Lower Back
- □ Shoulders
- □ Arms o Left o Right
- □ Legs o Left o Right
- □ Other _____

Cardiovascular
- □ High Blood Pressure
- □ Lowe Blood Pressure
- □ Chronic Congestive Heart Failure
- □ Heart Attack
- □ Phlebitis
- □ Varicose Veins
- □ Stroke / CVA
- □ Pacemaker / Similar Device
- □ Heart Disease
- □ Dizziness
- □ Vertigo
- □ Seizures

Respiratory
- □ Asthma
- □ Bronchitis
- □ Emphysema
- □ Chronic Cough
- □ Shortness of Breath
- □ Smoke _____

Digestive / Uro-genital
- □ Constipation
- □ Crohn's Disease
- □ Colitis
- □ Irritable Bowel Syndrome
- □ Ulcers
- □ Difficult Digestion
- □ Liver / Gall Bladder
- □ Kidney / Bladder

Skin Conditions
- □ Eczema
- □ Psoriasis
- □ Rash
- □ Warts
- □ Open Sores
- □ Bruise Easy

Arthritic Conditions
- □ Rheumatoid Arthritis
- □ Juvenile Rheumatoid Arthritis
- □ Systemic Lupus Erythematosus
- □ Osteoarthritis
- □ Gout
- □ Lyme Disease

Other Conditions
- □ Diabetes
- □ Epilepsy
- □ Cancer
- □ Hemophilia
- □ Scoliosis
- □ Fibromyalgia
- □ Polio / Post Polio
- □ HIV
- □ Stress
- □ Fainting
- □ Fever
- □ Insomnia
- □ Tuberculosis
- □ Poor Circulation
- □ Loss of Sensation

Women
- □ Menstrual Problems
- □ Menopausal Problems
- □ Pregnant o No o Yes
  Due Date _____
- □ Number of Children

Exercise / Sport
- □ Regular Exercise Type _____
  _____
  Times Per week _____
- □ Chronic Pain / Injury related to activity
- □ Acute Pain / Injury related to activity

I understand that this information is to help the therapist create a safe and effective treatment plan; therefore, I have answered all of the above questions truthfully.

Signature: _____ **Date:** _____

265 Sackville Dr • Lr. Sackville • NS • B4C 2R5 • 902.865.8500 • www.backtohealthchiropractic.ca

INFORMED CONSENT AND RELEASE OF INFORMATION

I understand that, as in all health care, there are some very slight risks associated with Massage Therapy, including, but not limited to muscle tenderness and/or soreness.

I hereby authorize the Registered Massage Therapists of Back to Health Wellness Clinic to perform any or all massage therapy treatment as deemed necessary.

The Registered Massage Therapists of Back to Health Wellness may disclose information from my records to doctor, hospital or others for continuous care and to any third party who requires that information in order to fulfil an obligation benefiting me.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, any amount authorized to be paid directly to this clinic by a third party will be credited directly to my account upon receipt. However, I clearly understand that if I suspend or terminate my care and treatment, any fees for services rendered to me will be immediately due and payable.

There will be a **$25.00 charge for Missed Appointments** that have not been cancelled 24 hours in advance.

I have read the above and agree to the stated procedures and give my consent to treatment.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____