Health History Intake Form

Please complete this form to the best of your knowledge.

Date: _____

PERSONAL INFORMATION

_____ _____ ____/____/____
Last Name First Name D.O.B. (mm/dd/yy)

_____ _____ _____ _____
Mailing Address City Province Postal Code

_____ _____ _____ _____
Home Telephone Business Telephone Other (cell phone) Email Address

_____ _____ _____
Occupation Doctor's Name Date of Last Medical

_____
How did you hear about me? (ie. internet, ART website, phone book, ad in paper, family/friend - who?)

CURRENT HEALTH STATUS

What are you seeking treatment for?_____

Was this a motor vehicle accident (MVA) or a workplace injury? Yes No
How long has the condition been bothering you?

_____

Have you ever undergone advanced imaging for the condition (CT scan, x-ray, MRI)? Yes No
If yes, when and where?

_____

Have you ever sought other treatment for this condition? Yes No
For any other condition/concern? Yes No

- ❑ Chiropractic care
  Doctor's name)_____
- ❑ Massage Therapy
  (Therapist's name)_____
- ❑ Naturopathic Doctor
  (Doctor's name) _____
- ❑ Acupuncturist
  (Doctor's name)_____
- ❑ Physiotherapy
  (Therapist's name)_____
- ❑ Medical Doctor
  (Doctor's name) _____
- ❑ Other
  (please specify)_____

Are there any other conditions you would like to discuss?_____

_____

Please list all **medications and supplements** you are currently taking, and indicate the **reason for use**:

_____

_____

please turn over.....

MEDICAL HISTORY

Please indicate which of the following you are currently experiencing, or have experienced in the past by writing (where applicable) **C** (for current) or **P** (for past)

CARDIOVASCULAR
- ❑ Stroke
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Circulatory Disorders
- ❑ Varicose Veins
- ❑ Pacemaker
- ❑ Phlebitis
- ❑ Heart Disease
- ❑ Chronic Congestive Heart Failure
- ❑ Myocardial Infarction

RESPIRATORY
- ❑ Emphysema
- ❑ Asthma
- ❑ Chronic Cough
- ❑ Bronchitis
- ❑ Breathing Difficulty
- ❑ Lung Disorder

NEUROLOGICAL
- ❑ Epilepsy
- ❑ Multiple Sclerosis
- ❑ Loss of Sensation
- ❑ Neuritis
- ❑ Other _____

DIGESTIVE & URINARY
- ❑ Chronic Abdominal Pain
- ❑ Prolonged Constipation
- ❑ Frequent Urination
- ❑ Diarrhea
- ❑ Irritable Bowel Syndrome
- ❑ Ulcerative Colitis
- ❑ Pelvic Inflammatory Disease
- ❑ Gastritis
- ❑ Liver/Gall Bladder
- ❑ Kidney/Bladder

SKIN
- ❑ Easily Bruise
- ❑ Eczema/Psoriasis
- ❑ Rash
- ❑ Cold Sores/Warts
- ❑ Herpes
- ❑ Athletes Foot
- ❑ Loss of Sensation
- ❑ Skin Conditions

_____

_____

HEAD & NECK
- ❑ Headache
- ❑ Migraine
- ❑ Visual Disturbances
- ❑ Earaches
- ❑ Hearing Problems
- ❑ Teeth/Jaw Pain
- ❑ Locked Jaw
- ❑ Sinus Pain
- ❑ Injury
- ❑ Dizziness/ Vertigo

SOFT TISSUE & JOINT Complaints

Left	Right	
❑	❑	Neck
❑	❑	Shoulder
❑	❑	Arm
❑	❑	Chest
❑	❑	Abdomen
❑	❑	Upper Back
❑	❑	Mid Back
❑	❑	Lower Back
❑	❑	Hip
❑	❑	Leg
❑	❑	Knee
❑	❑	Ankle

- ❑ Other_____

FEMALE
- ❑ Menstrual Problems
- ❑ Pregnant: Term _____
- ❑ Menopausal Problems
- ❑ Endometriosis
- ❑ Previous C-Section

MALE
- ❑ Haemorrhoids
- ❑ Prostate Problems
- ❑ Sexual Dysfunction
- ❑ Hernias

OTHER
- ❑ Diabetes
- ❑ Cancer
- ❑ HIV/AIDS
- ❑ Tuberculosis
- ❑ Hepatitis
- ❑ Osteoporosis
- ❑ Arthritis _____
- ❑ Allergies _____

LIFESTYLE CHECKLIST
- ❑ Exercise regularly _____x/week
- ❑ Consume caffeine _____x/week
- ❑ Consume alcohol _____x/week
- ❑ Smoke _____x/week

- ❑ Carpal Tunnel Syndrome
- ❑ Insomnia
- ❑ Fainting
- ❑ Chronic Fatigue Syndrome
- ❑ Seasonal Affective Disorder
- ❑ Fibromyalgia
- ❑ Scoliosis
- ❑ Haemophilia

INJURIES
- ❑ Muscle Strain _____

_____
- ❑ Ligament Sprain _____

_____
- ❑ Fracture _____

_____
- ❑ Whiplash _____

_____
- ❑ Herniated Disc _____

_____
- ❑ Other: _____

SURGICAL IMPLANTS
Pins, plates, wires, artificial joints:

_____

_____

_____

_____

Other:

_____

_____

_____

_____

I, _____, have completed this form to the best of my knowledge. I will notify my therapist if my health changes at any time, including diagnoses and other treatments I am undergoing (including medications).
I understand there is a risk to any treatment received, and my therapist will answer any and all questions I have relating to my treatment. I recognize my right to change, modify or stop my treatment at any time.

Date:_____ Signature:_____

Record Updated:

_____

_____

_____

INFORMED CONSENT FOR MASSAGE THERAPY SERVICES

Massage therapy is a comprehensive intervention involving a range of techniques to manipulate the soft tissues and joints of the body. The purpose of massage therapy is to prevent, develop, maintain, rehabilitate or augment physical function or relieve pain (Massage Therapy Act, 1991). Massage Therapists assess the whole person, taking into account every factor of physical function and how they relate, as well as focusing on the spiritual, mental and emotion aspects of each individual. Massage Therapy is a hands-on, therapeutic manipulation of muscles, connective tissue, tendons, ligaments and joints for the purpose of optimizing health. The Massage Therapist will take you through a comprehensive health history, physical assessment, and treatment, which may be repeated or updated throughout the treatment plan of each individual to monitor changes and progress. **The time taken to complete the initial assessment and reassessment will occur WITHIN your designated treatment time and is part of the cost of the entire visit.**

As a patient you will receive information about your assessment results and the proposed treatment, or an alternative course of action. You will be made aware of the cost of the treatment, nature of the treatment, consequences, benefits, adverse reactions of the treatment, contraindications and alternative options. As a patient you are empowered to become involved and participate in your treatment in collaboration with the Therapist. The Massage Therapist may practice multiple complimentary treatment modalities, which you will be made aware of before treatment. Modalities out of the Massage Therapy scope of practice will be practiced separately, not within the massage treatment.

There are some possible health risks/concerns to treatment by Massage Therapy. These include but are not limited to:

- Aggravation of pre-existing symptoms. Allergic reactions to lotions, gels, oils or any product including scents of aromatherapy and detergents.
- Pain, bruising, injury or re-injury. Extra concerns for those diagnosed with a serious health condition such as and not exclusive to congestive heart failure, stroke, blood clots, etc. due to the movement of blood/fluids and sympathetic stimulation.
- Light-headedness or fainting
- Muscle fatigue, possible strains and sprains with treatment or homecare (stretching, strengthening, range of motion, hydrotherapy, etc.)
- Psychosocial effects of 'Touch Triggered Memory'

I understand that a record will be kept of the health services provided to me. **This record will be kept confidential and will not be released to others unless so directed by myself when the law requires it.**
I understand the potential risks of treatment, which includes but is not limited to the list mentioned above.

I understand that my Massage Therapist will answer any questions that I have to the best of his/her ability. I understand that the results are not guaranteed. I do not expect the Massage Therapist to be able to anticipate and explain all the risks and complications. I will rely on the Massage Therapist to exercises judgement during the course of the treatment which they feel at that time is in my best interest based on the facts known to them. With this knowledge, I voluntarily consent to the assessment and therapeutic procedures mentioned above. I also confirm that I have the ability to accept this care of my own free will and choice.

Office Policies and Fees

30 minute treatment- $55 45 minute treatment- $70 60 minute treatment- $85 90 minute treatment- $125

It is our policy that 24 hours notice is required to cancel/re-schedule an appointment otherwise a fee of $50.00 will be charged. PLEASE INITIAL: _____

I understand that the Massage Therapist will not disclose or discuss treatment specifics over the phone or email. I understand that this office will not provide treatment options or change treatment protocol over email or phone with an appointment. We may send out clinic newsletters to patients who provide an email. We may also contact you over phone or email to change or modify an appointment. I understand that the Lakeside Clinic is not a Walk-In Clinic and an appointment is necessary. I declare that I have received a full and complete explanation of the treatment services that I may receive with my Massage Therapist and hereby authorize and consent to treatment. I agree to pay my full account at the time of each visit or treatment, including fees or services, administrative fees, late charges, and other applicable fees.

It is very important that you inform your Massage Therapist immediately of any disease process that you are suffering and any medications/over the counter drugs that you are currently taking. Please advise your Massage Therapist if you are pregnant, if you suspect you are pregnant, or if you are breast-feeding.

Patient Name: (Print):_____ Signature: _____

Massage Therapist: _____ Date: _____