Goldsworthy
chiropractic & wellness centre

Health History Form – Massage Therapy

The information request 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 confidential unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Phone #: C/H/W_____

Address: _____

Email Address: _____

Occupation: _____ Date of Birth: _____

Have you received massage therapy before? ▢ Yes ▢ No

Did a health care practitioner refer you for massage therapy? ▢ Yes ▢ No

If yes, please provide their name and address: _____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular

- ▢ high blood pressure
- ▢ low blood pressure
- ▢ chronic congestive heart failure
- ▢ heart attack
- ▢ phlebitis/varicose veins
- ▢ stroke/CVA
- ▢ pacemaker or similar device
- ▢ heart disease

Is there a family history of any of the above? ☐ Yes ☐ No

Respiratory

- ▢ chronic cough
- ▢ shortness of breath
- ▢ bronchitis
- ▢ asthma
- ▢ emphysema

Is there a family history of any of the above? ☐ Yes ☐ No

Infections

- ▢ hepatitis
- ▢ skin conditions
- ▢ TB
- ▢ HIV
- ▢ herpes

Other Conditions

- ▢ Loss of sensation
- ▢ Where? _____
- ▢ Diabetes
- ▢ Onset_____
- ▢ Allergies/hypersensitivity to what _____
- ▢ Type of reaction: _____
- ▢ _____
- ▢ Epilepsy
- ▢ Cancer
- ▢ Where? _____
- ▢ Skin conditions
- ▢ What? _____
- ▢ Arthritis

Is there a family history of arthritis? ☐ Yes ☐ No

Head/Neck

- ▢ history of headaches
- ▢ history of migraines
- ▢ vision problems
- ▢ vision loss
- ▢ ear problems
- ▢ hearing loss

Women

- ▢ pregnant due date _____
- ▢ gynecological conditions, what? _____

_____

Overall, how is your general health?

_____

Primary Care Physician:

_____

Address:

_____

_____

_____

Current Medications:

_____

_____

_____

_____

Condition it treats:

_____

_____

_____

_____

Are you currently receiving treatment from another health care profession?

▢Yes ▢ No

If yes, for what? _____

Surgery – date: _____

Nature: _____

_____

Injury – date: _____

Nature: _____

_____

Do you have any other medical conditions? (e.g., digestive conditions, hemophilia, osteoporosis, mental illness) ▢Yes ▢No

What: _____

Do you have any internal pins, wires, artificial joints, or special equipment?

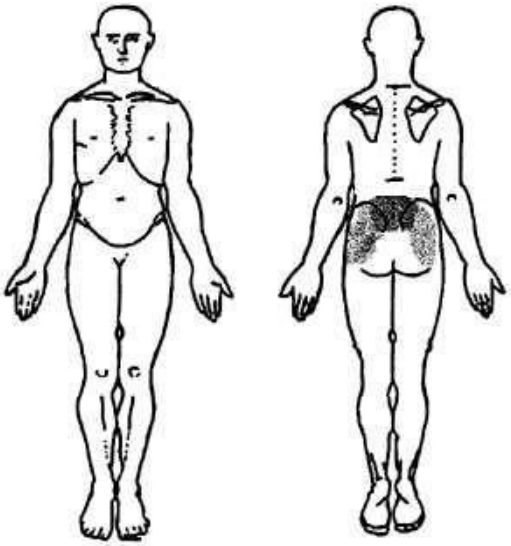
▢Yes ▢ No

What? _____

Where? _____

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort.

Please circle any areas of discomfort below.



Notes:

Date of Initial Health History: _____

Update 1 _____

Update 2 _____

Update 3 _____

Update 4 _____

Aimee Paikera
Goldsworthy Wellness Centre
168K Lexington Court, Waterloo, Ontario N2J 4R9
Telephone: 519-886-4814

Consent Form and Fee Schedule – Massage Therapy

The practice of massage therapy is the assessment of the soft tissue and joints of the body and the treatment and prevention of physical dysfunction and pain of the soft tissue and joints by manipulation to develop, maintain, rehabilitate, or augment physical function, or relieve pain. {Massage Therapy Act 1991}

Client Rights

- All client information (written or verbal) is confidential and will be safeguarded by your therapist, except when disclosure if required by law or by order of the court. Written authorization will be obtained prior to any release of client records.
- It is your right to refuse, modify or terminate treatment (or any aspect of treatment) at any time, regardless of any prior consent.
- You have the right to make decisions about the proposed treatment plan prior to and during its implementation.
- You have the right to make choices about the areas of your body that will be treated, and how much clothing you will remove or retain during the treatment.

Client Responsibility

- We rely on you to provide accurate, up-to-date health history information, and to inform us of any changes in your health status.

Massage Therapy Fees (HST included) *fees are subject to change

Initial Assessment	$110.00	Initial Assessment Student/Senior	$105.00
30-minute treatment	$ 80.00	30-minute Student/Senior Treatment	$ 75.00
45-minute treatment	$ 95.00	45-minute Student/Senior Treatment	$ 90.00
60-minute treatment`	$110.00	60-minute Student/Senior Treatment	$105.00
75-minute treatment	$130.00	75-minute Student/Senior Treatment	$125.00
90-minute treatment	$150.00	90-minute Student/Senior Treatment	$145.00

I, _____, confirm that I have read and fully understand all the information included in this consent document.

I confirm that I am capable to consent to the treatment and acknowledge that my consent is voluntary and may be withdrawn at any time.

I give consent to receive massage therapy and agree to the above fee schedule.

_____ _____

Client Signature Date

Aimee Paikera
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168K Lexington Court Waterloo, Ontario N2J 4R9
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MISSED APPOINTMENT AND LATE CANCELLATION FEE POLICY

We're glad you have chosen us to provide you with your health care. Your practitioner books your appointments to keep you in top shape. When you miss or cancel your appointment you affect your health and those of clients that could have used that time.

Our Centre requires 48 business hours' advanced notice in the event you need to reschedule or cancel an appointment. Appointments on Monday must be cancelled before the scheduled appointment time on the previous Thursday.

Full treatment price will be charged for appointments missed, cancelled, or rescheduled with less than 48 hours' notice.

Please be aware that in some cases repeat missed appointments can lead to termination of services. None of these fees are insurance reimbursable.

I _____, have read the above information that explains the missed appointment, late cancellation, and rescheduling fee policy. I understand that at least 48 business hours' notice is required to avoid these charges.

Signature: _____Date: _____

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