

M & Y Chiropractic Health and Wellness Centre
Confidential Health History Form

Date: _____
Name: _____ Date of Birth: (d/m/y) ____/____/____
Address: _____ Unit #: _____
City: _____ Prov.: _____ Postal Code: _____
Telephone: res: _____ bus: _____ cell: _____
E-mail address: _____
What is primary complaint? _____
How were you referred to our clinic? _____

HEALTH HISTORY: Please indicate conditions you are currently experiencing, or have experienced

RESPIRATORY

Chronic cough
Shortness of breath
Bronchitis
Asthma
Emphysema

OTHER CONDITIONS

Loss of sensation
Diabetes (onset: _____)
Arthritis (type: _____)
Epilepsy (type: _____)
Cancer (where: _____)
Allergies (type: _____)

WOMEN

Pregnant (due: _____)
Breast pain
Menstrual problems
Menopause

CARDIOVASCULAR

High blood pressure
Low blood pressure
CCHF
Heart attack
Phlebitis
Stroke/CVA
Pacemaker or similar device
Heart disease
Varicose veins (where: _____)

HEAD/NECK

Vision problems
Vision loss
Ear problems
Hearing loss
Headaches

SOFT TISSUE/JOINT DISCOMFORT (describe)

Neck: _____
Low back: _____
Mid back: _____
Upper back: _____
Shoulders: _____
Arms: _____
Legs: _____
Knees: _____
Other: _____

SKIN

Skin condition: _____
Bruise easily
Shingles (where: _____)

INFECTIONS

Hepatitis (type: _____)
Skin conditions (type: _____)
Tuberculosis (where: _____)
HIV/AIDS

WHAT IS YOUR HEALTH STATUS?

Current Medications: _____ Primary Care Physician: _____
Condition it treats: _____ Telephone: _____
Surgery: Nature: _____ Present Involvement in Other Health Care: yes no
Date: _____ If yes, please specify: _____
Injury: Nature: _____
Date: _____

Other Medical Conditions (e.g. digestive, gynecological conditions, hemophilia, etc.):

Of Special Note (e.g. presence of internal pins, wires, artificial joints, special equipment):

Please read carefully, and sign.

An accurate health history is important to assist in treating you safely. Feel free to ask any questions about the information being requested. If your health status changes in the future, please let us know.

I attest that the information I have provided is true and complete to the best of my knowledge. I also understand that the information on this form is confidential and will not be released without my written consent, unless allowed or required by law. I will be asked to provide written authorization for release of any information.

I acknowledge that I am responsible for any charges incurred in the course of my treatment and understand that a minimum of 24 hours notice is required to reschedule or cancel any appointment or a charge of the full fee plus GST for the appointment time booked will apply.

Massage Therapy is most fully experienced without clothing. However, if you are uncomfortable with this, it is totally up to your discretion and comfort, what you leave on. You will be covered completely with a sheet except for the area that is being worked on. All massages are **strictly therapeutic and non-sexual**. If any area that is being worked on is uncomfortable, you have the right to change your mind and ask the therapist to stop. ***Good communication is the key for your therapist in working within your comfort zone.***

I, as the client have the right to stop, clarify and ask questions about the massage. I also have the right to discontinue treatment at any time. I understand that the information I have provided on this form will remain confidential and will be used for no other purpose than the professional therapist's records.

I also understand that it is the therapist's right to discontinue treatment at any time and for any reason.



Signature: _____ Date: _____