The Centre for Chiropractic Health

Massage Patient Entrance Form

Date ____________________ Circle: Male Female

Name ____________________ Birth Date (D/M/Y) ____________________ Age __________

Address ____________________ City ____________________ Province __________

Postal Code ____________________ Home # ____________________ Cell # ____________________

Occupation ____________________ Employer ____________________

Work # ____________________ E-mail ____________________

Name of Emergency Contact ____________________

Contact # ____________________ Relation ____________________

Family Doctor & # ____________________ Surgeries/fractures &/or injuries: Y N

Medications ____________________

Other healthcare/practitioners: (Chiropractic, Exercises, etc.): ____________________

Prior Massage Therapy Care: Y N Reason for seeking care: ____________________

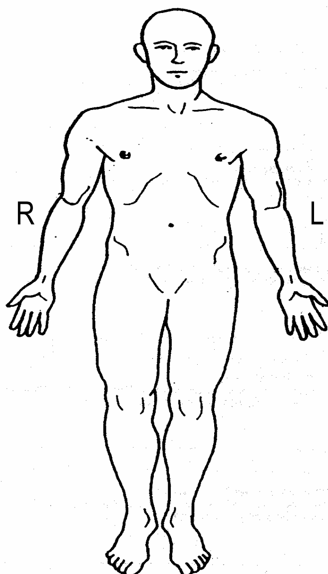
Motor Vehicle Accident: Y N If Y, Date: ____________________

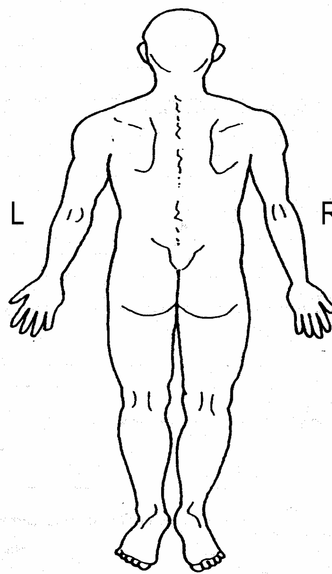
Additional relevant information: ____________________

Where do you feel your pain?

Please use the appropriate symbol (s) below. Include all affected areas. If pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels.

Ache > > > > >	Numbness = = = = =	Pins & Needles o o o o
Burning x x x x x	Stabbing / / / / / / / /	Throbbing ~ ~ ~ ~ ~ ~ ~





Health History Form

Please indicate conditions you are experiencing or have experienced:

Cardiovascular	Infections	Head/Neck
☐ 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	☐ 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	☐ history of headaches ☐ history of migraines ☐ vision problems ☐ vision loss ☐ ear problems ☐ hearing loss Women ☐ pregnant, due:__________ ☐ 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 professional? ☐ Yes ☐ No If yes, for what? ________________________ _______________________________________ Surgery – date _________________________ Nature: _______________________________ Injury – date ___________________________ Nature: _______________________________	Do you have any other medical condition? (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. ______________________________________ ______________________________________ ______________________________________

The Centre for Chiropractic Health

Confidential Consent Form for Massage Therapy

The massage therapist respects the patient's right to an informed and voluntary consent regarding care and treatment by obtaining his/her consent before providing treatment.

Your comfort and trust in this clinic is extremely important in providing an optimal patient/therapist relationship.

The treatment will be provided only when there is reasonable expectation that the treatment will be beneficial to the patient.

Before, during and/or after therapy, we encourage you to communicate to the therapist any aspect of the treatment in which you have concerns and/or questions.

Proper draping is always provided to ensure safety, comfort and privacy for all patients. Patients are asked to disrobe in private and prepare themselves on the massage table. You may choose to remove or leave on clothing, according to your own comfort level.

The massage therapist respects your right to modify, refuse, or terminate treatment, regardless of prior consent given.

This clinic respects the confidentiality of all patient information unless the law or court order requires disclosure. Information will not be released otherwise, unless written consent is obtained.

Massage Therapy Rates:

120 minutes - $140.00
90 minutes - $110.00
60 minutes - $ 80.00
45 minutes - $ 70.00
30 minutes - $ 55.00

* Receipts issued upon payment

*****CANCELLATION POLICY***** PLEASE CALL THE OFFICE **12 HOURS** IN ADVANCE TO CANCEL, AS SPACES FOR APPOINTMENTS ARE LIMITED. **A 100% CHARGE OF THE MASSAGE FEE WILL BE APPLIED FOR "no shows" or last minute cancellations.**

PAYMENT POLICY Payment is expected at the time of service.

I, ________________________________ (print name) have read and understand the fee schedule, payment policy and cancellation policy for Massage Therapy services. I understand my rights to consent to treatment.

____ ____

Signature Date