Confidential Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please not that all information provided below will be kept in confidence unless allowed or required by law. Your written permission will be required to release any information.

Name:	Contact Details:
_____	Home _____
Address:	Work _____ / Cell _____
Occupation: _____	Email _____
Male / Female	
Date of Birth _____/_____/_____	_____
Emergency Contact:	Phone:

Have you received massage therapy before? Yes ☐ No ☐
Have you been referred for massage therapy? Yes ☐ No ☐
If yes, please provide their name _____

Purpose of Visit? **Treatment** **Relaxation**

If you have indicated Treatment what areas are bothersome?

1. _____ Left Right
2. _____ Left Right
3. _____ Left Right

Please circle the symptoms you are experiencing:

Dull ache	Tingling	Twitching	Cramping	Burning	Stabbing
Sharp Pain	Stiffness	Radiating Pain	Swelling	Numbness	Weakness

Please indicate conditions you are experiencing or have experienced:

Cardiovascular

- ☐ high/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
- ☐ bruise easily
- ☐ warts, plantar/palmar/common
- ☐ TB
- ☐ HIV
- ☐ herpes

Head / Neck

- ☐ headaches/migraines
- ☐ vision problems
- ☐ ear problems
- ☐ hearing loss

Women

- ☐ pregnant, due:_____
- ☐ gynecological conditions? _____

Other Conditions

- ☐ epilepsy
- ☐ cancer
- ☐ thyroid
- ☐ diabetes
- ☐ lupus
- ☐ fibromyalgia
- ☐ chronic pain
- ☐ hepatitis, type: A B C
- ☐ loss of sensation
- ☐ allergies/hypersensitivity

To what? _____
Reaction? _____
Anaphylactic? _____

Bone / Joints / Muscle

- ☐ fracture, area: _____
- ☐ arthritis
- ☐ degenerating disc
- ☐ bursitis
- ☐ tendonitis

What is your current health: Poor Fair Good Excellent

Have you received massage therapy before? Yes No

Do you have any pins, prosthesis or joint replacements? Yes No

Please list any trauma / accidents / surgical procedures:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Please list any medications you are taking and what they are for:
(Please include any over the counter, homeopathic and natural medications)

1. . _____ For: _____
2. . _____ For: _____
3. . _____ For: _____
4. . _____ For: _____
5. . _____ For: _____

Do you have any other medical conditions that I should be aware of? Yes No
(e.g. digestive conditions, hemophilia, osteoporosis, mental illness) _____

Are you currently receiving treatment from another health care professional? Yes No
If yes, for what? _____

Who is your primary care physician?	
Name:	
Address:	
Phone:	

I certify that to the best of my knowledge, the above information is accurate and complete. I will keep you informed of any changes in my health status:

Client Signature _____

Date: _____

Date of Initial Health History: _____

Update 1 _____

Update 2 _____

Update 3 _____

Stacie Thompson, Registered Massage Therapist
Carp Chiropractic Clinic.

CANCELLATION POLICY

Because appointment times are reserved specially for each client and we are unable to fill appointments that are cancelled on short notice, the following policy is in place:

In order to minimize disruptions to our schedule, we require 24 hours' notice to change, cancel and/or reschedule Massage Therapy appointments. If 24 hours is not given, the client will be responsible to pay for the full price of the scheduled appointment.

Appointments cancelled with less than 24 hours' notice are charged the full amount and must be paid prior to the next appointment. This fee is waived for regular clients for their first cancellation with less than 24 hours' notice, or in the case of emergency.

Cancellation fees are in effect to ensure that therapists are compensated for their time. As a busy clinic we often turn away clients, please keep in mind that if inadequate notice is given it is extremely difficult to fill vacant spots this not only negatively impacts the therapists, but also affects clients. Please be courteous to your therapist and other clients by respecting our policies.

GIFT CERTIFICATES

There is no expiration date on gift certificates.

Gift Certificates purchased will be worth actual price at time of sale. When redeemed its face cash value will be deducted from the amount due for the service received.

Gift Certificates must be presented at time of service. Lost or stolen Gift Certificates will not be replaced. Length of session shown on Gift Certificates CANNOT be divided into multiple shorter sessions.

All Gift Certificates sold are FINAL sale.

Signed _____

Dated _____