Massage Therapy Health History
Paramount Family Chiropractic

First Name: _____ **Last Name**: _____

Address: _____**City**: _____ **Prov**: _____**Postal Code**: _____

Email address: _____ **Phone #**_____

Date of Birth: _____ **Gender**: M or F **Occupation**: _____

How were you referred to our clinic? _____

Emergency Contact: _____**Relation**: _____ **Phone**: _____

Primary care Physician: _____

Address: _____ **Phone**: _____

History of Massage Therapy: _____

Payment is made directly to the clinic, reimbursement is provided to you by your insurer.

Health Benefits (Private – not OHIP)

Employer: _____ Insured: _____

Insurance Company: _____

Carrier#: _____ Group#: _____ Client ID: _____

Annual Coverage for Massage Therapy $_____

Doctor referral required? Yes or No *Please provide copy of MD referral if applicable

Workers Compensation (WSIB)

Injury: _____ Date of Injury: _____

Employer: _____ Claim #: _____

Motor Vehicle Accident (MVA) * Auto Intake, Disability Index, Release of Information forms

Injury: _____ Date of Accident: _____

Auto Insurer: _____ Claim #: _____ Policy#: _____

Insurance Rep: _____ Phone: _____ Fax: _____

***All private health care benefits must first be exhausted prior to utilizing Auto Insurance benefits.**

Once you have completed this page, please remove and hand over to the receptionist who will then add your new account information to our database. Please complete the two remaining pages and give to your Massage Therapist.

Name: _____

Please check all that apply, circle and/or list specific areas/conditions that are current or past.

Muscular

- ❑ Headache/Migraines
- ❑ Face/Jaw (TMJ)
- ❑ Neck
- ❑ Shoulder - Left/Right
- ❑ Arm pain - Left/Right
- ❑ Hand/Fingers – Left/Right
- ❑ Upper/mid/low back
- ❑ Abdominal
- ❑ Gluteal (butt)/Hip
- ❑ Leg/Foot – Left/Right
- ❑ Knee/Ankle – Left/Right
- ❑ Other _____

Cardiovascular

- ❑ High/Low blood pressure
- ❑ Poor circulation
- ❑ Diabetes Type 1 or 2
- ❑ Angina
- ❑ Heart disease/Attack
- ❑ Blood clots
- ❑ Congestive heart failure
- ❑ Stroke/CVA
- ❑ Thrombosis/Embolism
- ❑ Anemia (low iron)
- ❑ Varicose veins/Phlebitis
- ❑ Other _____

Skin Conditions

- ❑ Allergies _____
- ❑ Rashes
- ❑ Wounds/cuts
- ❑ Abrasions
- ❑ Scars
- ❑ Ulcers
- ❑ Moles/Skin Tags
- ❑ Psoriasis/Eczema
- ❑ Bruise easily/sensitivities
- ❑ Adipose (Fat/Lymphoma)
- ❑ Melanoma
- ❑ Other _____

Pathology

- ❑ Liver
- ❑ Kidney
- ❑ Bladder
- ❑ Cancer _____
- ❑ Epilepsy
- ❑ Hernia(s)_____
- ❑ Hemophilia
- ❑ Other _____

Nervous System

- ❑ Nerve Impingement
- ❑ Loss of Sensation
- ❑ Nerve Pain
- ❑ Tingling
- ❑ Cold/Hot
- ❑ Fatigue
- ❑ Stress
- ❑ Insomnia
- ❑ Other _____

Infections

- ❑ Herpes
- ❑ Hepatitis (A/B/C)
- ❑ Meningitis
- ❑ Warts (hands/feet)
- ❑ Nail fungus (hands/feet)
- ❑ Athlete's Foot
- ❑ Tuberculosis (TB)
- ❑ HIV/AIDS

Respiratory

- ❑ Breathing difficulties
- ❑ Chronic cough/Bronchitis
- ❑ Sinus congestion
- ❑ Asthma
- ❑ Emphysema
- ❑ Smoker
- ❑ Sleep Apnea
- ❑ Other _____

Digestive

- ❑ Constipation
- ❑ Diarrhea
- ❑ Gas (Flatulence)
- ❑ Ulcers
- ❑ Irritable Bowel Syndrome
- ❑ Crohn's Disease
- ❑ Celiac Disease (Gluten)
- ❑ Other _____

Women

- ❑ Menstrual conditions
- ❑ Breast conditions
- ❑ Gynecological conditions
- ❑ Pregnancy due _____
- ❑ Complications _____
- ❑ Children _____
- ❑ C-Sections _____
- ❑ Other _____

Other

- ❑ Cerebral Palsy
- ❑ Parkinson's
- ❑ Fibromyalgia
- ❑ Multiple Sclerosis
- ❑ Mental Conditions
- ❑ Eye Conditions
- ❑ Ear Conditions
- ❑ Sinus Congestion
- ❑ Gout
- ❑ Lupus
- ❑ Shingles
- ❑ Herniated/Bulging Disc(s)

Conditions not listed, indicate below

_____

_____

_____

Name: _____

Surgeries and dates: _____

Injuries and date: _____

Internal wires, pins, artificial joints or special equipment: _____

Are you seeing other health care providers outside of your family physician? Yes or No

If yes, to treat: _____

Family history of any listed conditions: _____

Other medical conditions not already listed: _____

Current medications including last 24 hrs: _____

Conditions they treat: _____

What is your general health? _____

Rest

How restful is your average night sleep?	3-4 hrs <	5-6 hrs	7-8 hrs	9 hrs+
Do you feel well rested in the morning?	Always	Sometimes	Rarely	Never

Stress Levels

Are you generally…	Calm	Anxious	Irritable	Angry
Do you manage your stress levels?	Yes	Occasionally	Rarely	Never

If yes, how so? _____

Please circle any of the following topics for any additional information you would like to receive,
Chiropractic Posture Orthotics Nutrition 5 Star Gym Membership Personal Training

Privacy and Office Policies

All medical information submitted is strictly confidential in only the Paramount Family Chiropractic office. All personal contact information is viewed by our office staff, doctors and therapist. All personal medical information is viewed only by doctors and therapists. All client/patient information is confidential except where required by law and only then with your consent. Please do not hesitate to contact your health provider if you would like to discuss concerns about your personal information. Our office may contact you to book, reschedule and confirm appointments. In an effort to become paperless, an option to update or add your health history form to our online database is available through your email address. Our office may also contact you to send in-office promotions, classes and health information to your email address if you choose to provide it.

I have stated all medical conditions and will update my RMT of any changes in my health status. I do understand that my health history information is used to treat me safely and is confidential unless allowed by law. My written permission will be required to release any health information. I have the right to stop, change or request modification of my treatment at any time. I release the RMT from all liability and consent to treatment following an assessment by the RMT. **I assume payment responsibilities for all Insurance treatment plans that may become rejected**.

APPOINTMENTS CANCELLED WITHOUT 24 HOURS NOTICE WILL RESULT IN A FULL TREATMENT CHARGE.

Signature: _____ Date: _____