

# *Back to Health* **WELLNESS**

The information on this form is confidential and will be used for the therapist to evaluate and assess your condition and physical basis to determine a course of treatment. An accurate health history is important to ensure that it is safe for you to receive massage treatment. If your health status changes in the future please let us know.

***We regret we must charge a missed appointment fee of \$25.00 for an appointment cancelled with less than 24 hours notice.***

Name: \_\_\_\_\_ Telephone: Work \_\_\_\_\_ Home \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female Occupation: \_\_\_\_\_

Who to contact in case of an emergency: \_\_\_\_\_ Relation: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Physician's Number: \_\_\_\_\_

Are you currently receiving treatment from another Health Care Practitioner? If so, please indicate why: \_\_\_\_\_

**Where did you hear about our Clinic?**

- Article  Name of friend \_\_\_\_\_
- Website  Name of Doctor \_\_\_\_\_
- Other \_\_\_\_\_

**Can you please list any previous injuries, surgeries serious illness or allergies:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Do you have any of the following?**

- Wires  Artificial Joints
- Internal Pins  Wheelchair
- Walker  Cane
- Other \_\_\_\_\_

**Current Medication(s)**

<b>Name:</b>	<b>For what Condition:</b>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Is this your first massage treatment?  No  Yes

# *Back to Health*

## WELLNESS

Please check or fill in the appropriate information:

What is your primary complaint? \_\_\_\_\_

### Head / Neck

- Headaches
- Migraines
- Sinus Problems
- Vision Problems
- Hearing Loss

### Muscles / Joints

- Neck
- Upper Back
- Mid Back
- Lower Back
- Shoulders
- Arms     Left    Right
- Legs     Left    Right
- Other \_\_\_\_\_

### Cardiovascular

- High Blood Pressure
- Low Blood Pressure
- Chronic Congestive Heart Failure
- Heart Attack
- Phlebitis
- Varicose Veins
- Stroke / CVA
- Pacemaker / Similar Device
- Heart Disease
- Dizziness
- Vertigo
- Seizures

### Respiratory

- Asthma
- Bronchitis
- Emphysema
- Chronic Cough
- Shortness of Breath
- Smoke \_\_\_\_\_

### Digestive / Uro-genital

- Constipation
- Crohn's Disease
- Colitis
- Irritable Bowel Syndrome
- Ulcers
- Difficult Digestion
- Liver / Gall Bladder
- Kidney / Bladder

### Skin Conditions

- Eczema
- Psoriasis
- Rash
- Warts
- Open Sores
- Bruise Easy

### Arthritic Conditions

- Rheumatoid Arthritis
- Juvenile Rheumatoid Arthritis
- Systemic Lupus Erythematosus
- Osteoarthritis
- Gout
- Lyme Disease

### Other Conditions

- Diabetes
- Epilepsy
- Cancer
- Hemophilia
- Scoliosis
- Fibromyalgia
- Polio / Post Polio
- HIV
- Stress
- Fainting
- Fever
- Insomnia
- Tuberculosis
- Poor Circulation
- Loss of Sensation

### Women

- Menstrual Problems
- Menopausal Problems
- Pregnant    No    Yes
- Due Date \_\_\_\_\_
- Number of Children

### Exercise / Sport

- Regular Exercise Type \_\_\_\_\_
- Times Per week \_\_\_\_\_
- Chronic Pain / Injury related to activity
- Acute Pain / Injury related to activity

I understand that this information is to help the therapist create a safe and effective treatment plan; therefore, I have answered all of the above questions truthfully.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## INFORMED CONSENT AND RELEASE OF INFORMATION

I understand that, as in all health care, there are some very slight risks associated with Massage Therapy, including, but not limited to muscle tenderness and/or soreness.

I hereby authorize the Registered Massage Therapists of Back to Health Wellness Clinic to perform any or all massage therapy treatment as deemed necessary.

The Registered Massage Therapists of Back to Health Wellness may disclose information from my records to doctor, hospital or others for continuous care and to any third party who requires that information in order to fulfil an obligation benefiting me.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, any amount authorized to be paid directly to this clinic by a third party will be credited directly to my account upon receipt. However, I clearly understand that if I suspend or terminate my care and treatment, any fees for services rendered to me will be immediately due and payable.

There will be a **\$25.00 charge for Missed Appointments** that have not been cancelled 24 hours in advance.

I have read the above and agree to the stated procedures and give my consent to treatment.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Subscriber Enrollment

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As an extension of the care you receive in our practice, may we add you as a subscriber to our website that will help you...

**Get Well**  
**and**  
**Stay Well.**



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First name : \_\_\_\_\_ Last name : \_\_\_\_\_

Date of birth : \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Email address : \_\_\_\_\_

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Naturally you can unsubscribe at any time.

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