Name: _____ Date of birth: _____

Address: _____ Postal Code: _____

Phone (H): _____ Alternate Phone: _____

Email Address: _____

Occupation: _____ Employer: _____

Emergency Contact Name: _____ Contact Number: _____

Relationship to emergency contact: _____

How did you hear about our office? _____

Main Complaint & Duration:

_____

Secondary complaint:

_____

Are you pregnant? _____ How many weeks? _____ Due date: _____

Please list any previous or current treatments you are undergoing:

_____

Please list all medications, vitamins and supplements you are currently taking:

_____

Please list any allergies: _____

Have you ever experienced any of the following?

☐ Cancer ☐ Heart Disease ☐ High blood Pressure ☐ Hemophilia ☐ Arthritis
☐ Diabetes ☐ Stroke ☐ Epilepsy ☐ Varicose Veins ☐ Neurological Problems

Any major injuries, accidents (including MVA), traumas (physical or emotional) hospitalizations or surgeries?
If so, please explain:

_____

Please check any of the following that currently apply to you:

☐ Headaches ☐ Fainting/Dizziness ☐ Insomnia ☐ Muscle Aches ☐ Chest Pain
☐ Constipation ☐ Numbness/Tingling ☐ Indigestion ☐ Swelling/Inflammation
☐ Infection ☐ Contagious Disease ☐ Pins/Plates/Prosthesis ☐ Cold hands/feet
☐ Other: _____

Please see reverse side →

PLEASE READ AND SIGN

This agreement and the contents of this file are confidential. The data will not be shared outside of Complete Health without client permission. The information is to assist the therapists in providing the safest and most effective treatment plan for you.

I understand that the massage therapist is providing massage therapy services within their scope of practice. I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended by my therapist.
I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment.
I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.
I understand that the treatment of massage therapy provided by the therapist when requested without a chiropractic exam/assessment is separate and distinct from the practice of chiropractic provided by Dr. Caitlin Zietz and Dr. Chris Yavis at Complete Health. I hereby waive all liability towards the above mentioned doctors directly should any injury or malpractice occur from any treatment provided by the massage therapist.
I have read above noted consent and I have had the opportunity to question the contents of my therapist. By signing this form, I confirm to my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatments as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

CANCELLATION POLICY

We require **24 hours notice** for cancellation of Chiropractic, Acupuncture, Naturopath and Massage appointments otherwise the full cost of the treatment will be charged to you.
We understand some circumstances are beyond your control, so please discuss with us when cancelling.
No shows will be charged the full treatment amount.

Under Canada's new Anti-Spam Legislation, we are required to ask you for your consent to contact you via e-mail.

Do you consent to Email Appointment Reminders? ☐ YES ☐ NO

Do you consent to being contacted by our clinic staff via email? ☐ YES ☐ NO

Patient Name: _____

Date: _____

Signature of Patient or Guardian: _____