

MASSAGE THERAPY HEALTH HISTORY FORM

Name _____ Date _____
 Address _____ Unit # _____ City _____ Postal Code _____
 Phone Home _____ Work _____ ext _____ Cell _____
 Date of Birth dd/mm/yyyy _____ Age _____ Male / Female _____
 Occupation _____ Email _____

How did you hear about our clinic? Check all that apply:

Friend (Name) _____ Colleague (Name) _____
 Internet (Google) Passing by Phone Book Other _____

What is Your Primary Complaint? _____

Health History: Please indicate conditions you are experiencing, or have experienced:

<p>Respiratory</p> <p><input type="checkbox"/> chronic cough <input type="checkbox"/> shortness of breath <input type="checkbox"/> bronchitis <input type="checkbox"/> asthma <input type="checkbox"/> emphysema</p> <p>Cardiovascular</p> <p><input type="checkbox"/> high blood pressure <input type="checkbox"/> low blood pressure <input type="checkbox"/> CCHF <input type="checkbox"/> heart attack <input type="checkbox"/> phlebitis <input type="checkbox"/> stroke / CVA <input type="checkbox"/> pacemaker or similar device <input type="checkbox"/> heart disease</p> <p>Skin</p> <p><input type="checkbox"/> skin conditions</p>	<p>Other Conditions</p> <p><input type="checkbox"/> loss of sensation <input type="checkbox"/> diabetes (onset: _____) <input type="checkbox"/> allergies _____ <input type="checkbox"/> epilepsy <input type="checkbox"/> cancer <input type="checkbox"/> arthritis <input type="checkbox"/> scoliosis</p> <p>Head & Neck</p> <p><input type="checkbox"/> vision problems <input type="checkbox"/> vision loss <input type="checkbox"/> ear problems <input type="checkbox"/> hearing loss</p> <p>Infections</p> <p><input type="checkbox"/> hepatitis <input type="checkbox"/> TB <input type="checkbox"/> HIV</p>	<p>Women</p> <p><input type="checkbox"/> pregnant (due: _____)</p> <p>Soft Tissue/Joint Discomfort and its Nature</p> <p><input type="checkbox"/> neck _____ <input type="checkbox"/> low back _____ <input type="checkbox"/> mid back _____ <input type="checkbox"/> upper back _____ <input type="checkbox"/> shoulders _____ <input type="checkbox"/> arms _____ <input type="checkbox"/> legs _____ <input type="checkbox"/> knees _____ <input type="checkbox"/> other _____</p> <p>What is your general health status?</p> <p>_____ _____ _____ _____</p>
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Current Medications: _____ **Primary Care Physician:** _____
 Condition it Treats: _____ Address: _____

Surgery: _____ Date _____ **Present Involvement in Other Health Care:** Y / N
 Nature _____ If yes, please specify: _____

Injury: _____ Date _____
 Nature _____

Other Medical Conditions (e.g., digestive conditions, gynecological conditions, hemophilia, etc.): _____

Of Special Note (presence of internal pins, artificial joints, special equipment): _____

**** FOR CLINIC USE ONLY ****

Date	Changes in Health History	Signature
	No [] Yes []	
	No [] Yes []	
	No [] Yes []	
	No [] Yes []	

OFFICE POLICY

Welcome to King West Chiropractic Health Centre. Please take a few moments to read over our Office Policy. We will be happy to answer any questions you may have regarding this policy or other clinic procedures.

Clinic Hours: Monday to Friday, 8:00 am to 6:30 pm

Chiropractic Fee Schedule*

Initial Examination (<i>Chiropractic / Acupuncture / Foot Orthotics</i>)	78.00
Adjustment	45.00
Acupuncture	50.00
One pair of Custom Foot Orthotics	475.00
Second pair of Custom Foot Orthotics (<i>if ordered on the same day</i>)	275.00
One pair of Orthotic Shoes	550.00

Massage Therapy Fee Schedule*

30 min treatment	55.00 + <i>hst</i>
45 min treatment	69.00 + <i>hst</i>
60 min treatment	89.00 + <i>hst</i>
75 min treatment	112.00 + <i>hst</i>
90 min treatment	125.00 + <i>hst</i>

Osteopathy Fee Schedule*

60 min initial treatment	140.00
45 min subsequent treatment	110.00

**All rates subject to change.*

Insurance

Many benefit plans cover some or all of our services. While our office does not deal directly with insurance companies, we do issue official receipts which may be submitted for reimbursement.

Massage Therapy and Osteopathy Missed Appointment Policy

24 hours notice is required when canceling or rescheduling massage/osteopathic appointments.

If we are unable to fill the timeslot patients will be responsible for the full fee of the missed appointment.

*** KWC is a scent-free clinic – please refrain from wearing perfume or cologne ***

Privacy Policy

The personal information collected is for limited and confidential use by the clinic. The information is not shared. We reserve the right to contact you on occasion for the following purposes: confirming appointments, clarifying your account and clinic updates/promotions.

Please check this box if you consent to receiving our clinic newsletter (sent by email once per month).

Email _____

Patient Signature _____

Date _____