Chiropractic
Acupuncture
Massage Therapy
Foot Orthotics
Naturopathic Medicine

KING WEST CHIROPRACTIC HEALTH CENTRE
145 King St. West, Concourse Level M5H 1J8 Tel: 416-815-9595 Fax: 416-815-9009
Email: kwc@bellnet.ca www.kingwestchiropractic.com

# 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:*

**Respiratory**

☐ chronic cough
☐ shortness of breath
☐ bronchitis
☐ asthma
☐ emphysema

**Cardiovascular**

☐ high blood pressure
☐ low blood pressure
☐ CCHF
☐ heart attack
☐ phlebitis
☐ stroke / CVA
☐ pacemaker or similar device
☐ heart disease

**Skin**

☐ skin conditions

**Other Conditions**

☐ loss of sensation
☐ diabetes *(onset: _____)*
☐ allergies_____
☐ epilepsy
☐ cancer
☐ arthritis
☐ scoliosis

**Head & Neck**

☐ vision problems
☐ vision loss
☐ ear problems
☐ hearing loss

**Infections**

☐ hepatitis
☐ TB
☐ HIV

**Women**

☐ pregnant *(due: _____)*

**Soft Tissue/Joint Discomfort and its Nature**

☐ neck _____
☐ low back _____
☐ mid back _____
☐ upper back _____
☐ shoulders _____
☐ arms _____
☐ legs _____
☐ knees _____
☐ other _____

**What is your general health status?**

_____
_____
_____
_____

**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 [ ] | |

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# 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 *(Chiropractic / Acupuncture / Foot Orthotics)* | 78.00 |
| Adjustment | 45.00 |
| Acupuncture | 50.00 |
| One pair of Custom Foot Orthotics | 475.00 |
| Second pair of Custom Foot Orthotics *(if ordered on the same day)* | 275.00 |
| One pair of Orthotic Shoes | 550.00 |

**Massage Therapy Fee Schedule***

| | |
|---|---|
| 30 min treatment | 55.00 + *hst* |
| 45 min treatment | 69.00 + *hst* |
| 60 min treatment | 89.00 + *hst* |
| 75 min treatment | 112.00 + *hst* |
| 90 min treatment | 125.00 + *hst* |

**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.***

**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** _____