Vita | Chiropractic and Wellness Centre

Health History Form

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

Name_____
Phone #_____
Address:_____
Occupation:_____
Date of Birth:_____
Have you ever received massage therapy before? Yes ☐ No ☐
Did a health care practitioner refer you for massage therapy? Yes ☐ No ☐
If yes, please provide their name and address_____
_____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
- High blood pressure ☐
- Low blood pressure ☐
- Congestive heart failure ☐
- Heart Attack ☐
- Phlebitis/varicose veins ☐
- Stroke/CVA ☐
- Pacemaker or similar device ☐
- Heart Disease ☐

Is there a family history of any of the above? Yes ☐ No ☐

Respiratory
- Chronic cough ☐
- Shortness of breath ☐
- Bronchitis ☐
- Asthma ☐
- COPD ☐

Is there a family history of any of the above? Yes ☐ No ☐

Infections
- Hepatitis ☐
- Skin conditions: explain_____ _____
- TB ☐
- HIV ☐
- Herpes ☐

Other Conditions
- Loss of sensation, where? _____
- Diabetes, onset:_____
- Allergies/hypersensitivity to What?_____

Epilepsy
Cancer_____

Degenerative Disc Disease, what level:_____

Arthritis ☐

Is there a family history of any of the above? Yes ☐ No ☐

Head/Neck
- History of headaches ☐
- History of migraines ☐
- Vision problems ☐
- Vision loss ☐
- Ear problems ☐
- Hearing loss ☐

Women
Pregnant? Due:_____
Gynaecological conditions:
_____

Overall how is your general health?_____

Primary Care Physician:
_____
Address:
_____
_____
_____

Current Medications:_____
_____
_____

Condition it treats:
_____

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) Yes ☐ No ☐
What?_____

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Are you currently receiving treatment from another health care professional? Yes ☐ No ☐ If yes, for what?_____ _____ Surgery - date_____ Reason:_____Injury - date_____ Nature:_____	Do you have any internal pins, wires, artificial joints or special equipment? Yes ☐ No ☐ What?_____ Where?_____ What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort:_____ _____

I understand that the information I have provided is true and complete to the best of my knowledge.
I also understand that the information I have provided on this form is confidential and will not be released without my written consent.
I consent to the therapeutic massage treatment by the RMT at Vita Chiropractic and Wellness Center.

I understand that 24 hours notice is required to reschedule all future appointments, or a charge will be applied (half the fee for your first time, and the full fee the second time)

_____ Initial

I give Vita Chiropractic and Wellness Center and its staff permission to release my health and billing information to my extended health care benefits company, my motor vehicle accident insurance company and/ or WSIB.

_____ _____

Signature **Today's Date**

_____

Guardian Signature

Notes:

Date of Initial Health History:
_____
Update 1_____
Update 2_____
Update 3_____
Update 4_____