REDHILL PHYSIO & CHIROPRACTIC

DR. FRANK RAMELLI – CLINIC DIRECTOR drframelli@rogers.com www.redhillphysio.com

Massage Therapy
Health History and Entrance Form

A complete health history helps us ensure it is safe to provide you with a massage treatment; please let us know if your status changes so we can update your form. All information given to us is confidential.

Name _____ Email: _____

Home Phone _____ Cell Phone _____ Work Phone _____

Street _____ Unit ____ City _____ Prov. ____ Postal Code _____

Date of Birth (DD-MM-YY) _____ Age ____ Gender _____ Occupation _____

How did you hear about us? _____

Do you have insurance coverage for massage? Y/N If yes, were you referred by your doctor? Y/N

Doctor's Name _____ Phone _____ Last check-up date _____

Have you had a professional massage before? ☐ Yes ☐ No If yes, when? _____

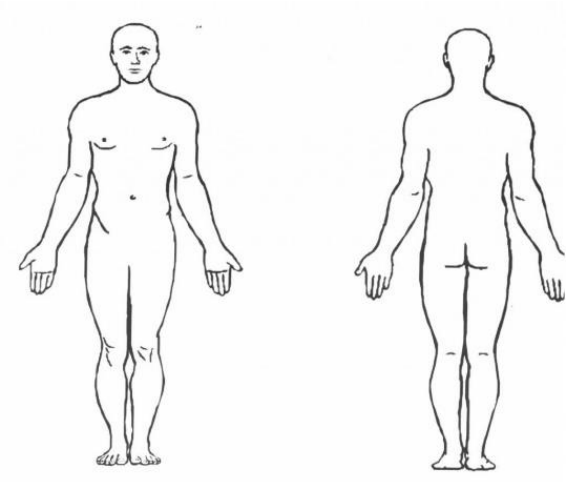
Do you see other health care practitioners? ☐ Chiro ☐ Physio ☐ Naturopath ☐ Osteopath

Current Medications: _____

Previous Major Illness/Operations (include dates) _____

Motor Vehicle Accident ☐ Yes ☐ No If yes, when? _____

Please indicate areas you would like us to focus on and your primary area of complaint



What are your primary complaints?

_____

_____

_____

_____

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Healthy History (please check all that apply to you)

Respiratory
- ☐ Chronic cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Emphysema
- ☐ Family history any of the above

Joint/Muscle
- ☐ Jaw
- ☐ Neck
- ☐ Shoulders
- ☐ Arms
- ☐ Hands
- ☐ Upper back
- ☐ Mid back
- ☐ Low back
- ☐ Hips
- ☐ Knees
- ☐ Feet

Reproductive
- ☐ Prostate problems
- ☐ Pregnant, due _____
- ☐ Gynecological conditions

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart attack/ disease
- ☐ Congestive heart failure
- ☐ Stroke/aneurysm
- ☐ Pacemaker
- ☐ Varicose veins/phlebitis
- ☐ Family history any above

Infections
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ HIV/AIDS
- ☐ Herpes
- ☐ Skin conditions
  What _____

EENT
- ☐ Vision loss/problems
- ☐ Dental problems
- ☐ Hearing loss/ear problems
- ☐ Hearing aid
- ☐ Sinus problems
- ☐ Allergies/hypersensitivity to type of reaction _____

Neuromuscular conditions
- ☐ Osteoporosis
- ☐ Mental illness
- ☐ Family history of any of above
- ☐ Artificial implants/pins/plates; where _____

Other
- ☐ Arthritis OA/RA
- ☐ Headaches/migraines
- ☐ Loss of sensation /numbness/tingling
- ☐ Diabetes, onset _____
- ☐ Cancer, where _____
- ☐ Epilepsy
- ☐ Haemophilia

Please read and sign:

- I attest that the information I have provided is true and complete to the best of my knowledge.
- I understand the information I have provided on this form is confidential and will not be released without my written consent.
- I understand that the therapist can end treatment at any time due to inappropriate behavior.
- I consent to a health assessment/reassessments and therapeutic massage treatment at Redhill Physio and Chiropractic.
- I authorize Redhill Physio and Chiropractic to contact my doctor or other health care professional listed above if required for treatment purposes.
- I understand that all sessions include pre-health assessment and change time.
- I understand 24 hours' notice is required to reschedule all future appointments, or full charges will apply.
- I authorize my health file to be transferred to another massage therapist at Redhill Physio and Chiropractic if a new therapist begins treating patients at Redhill Physio and Chiropractic.
- I am aware I may experience possible side effects from the treatment, such as temporary discomfort with the muscles (24-48 hours post treatment), bruising and dizziness.

Signature _____ Today's Date _____