AURORA
MASSAGE & CHIROPRACTIC
WELLNESS CENTRE INC.

Health History Form

Name: _____ H Phone #: _____

Address: _____ C Phone#: _____

City: _____ Postal Code: _____

Birth Date: Year / Month / Day Occupation: _____

Email: _____

Would you like to receive automatic appointment reminders via email? Yes No

Emergency Contact & relationship to you: _____Phone #:_____

Family Physician & Address: _____Phone #:_____

How did you hear of us? _____

What brings you in for treatment? _____

Health History Information:

How is your overall health? _____

- Have you taken any anti-inflammatory medications, pain killers (including aspirins) muscle relaxants or mood altering medications within the past 12 hours? If yes what and how much?

  _____

- List any stress reduction or exercise activities you do on a regular basis (including frequency):

  _____

- Please list any and all Allergies you may have

  _____

Previous History:

- Surgeries (including year and type of surgery): _____
- Accidents (including year and type of accident): _____
- Of special note (pins, wires, artificial joints/limbs etc): _____

Current Medications:

Please provide the name of the medications and what condition you are taking it for:

_____

_____

Are you currently involved with other Health Care Practitioners? **Yes/No** please indicate below

Please indicate if any of the following conditions apply to you (past or present):

Head/Neck
- ❑ headaches
- ❑ neck pain
- ❑ whiplash
- ❑ tooth/jaw/ear pain
- ❑ vision problems/loss
- ❑ head trauma/contusions
- ❑ loss of coordination
- ❑ hearing problems

Respiratory System
- ❑ asthma/bronchitis
- ❑ chronic cough
- ❑ emphysema
- ❑ shortness of breath
- ❑ smoker
- ❑ sinus problems
- ❑ allergies/hay fever
- ❑ pneumonia
- ❑ SARS y/n date:

Muscle/Joint Pain
- ❑ neck
- ❑ low/mid/upper back
- ❑ shoulder/arms
- ❑ hip/leg/knee/ankle
- ❑ other:

Nervous System
- ❑ multiple sclerosis (MS)
- ❑ Parkinson's disease
- ❑ sciatica
- ❑ weakness/paralysis
- ❑ numbness/tingling
- ❑ herpes/shingles
- ❑ epilepsy/seizures
- ❑ loss of sensation

Skin
- ❑ open sores/cuts/wounds
- ❑ rashes/athlete's foot
- ❑ eczema/psoriasis
- ❑ bruise easily
- ❑ other:

Muscle/Joints
- ❑ muscle cramps
- ❑ sprain/strain
- ❑ tendonitis/bursitis
- ❑ limitation of movement
- ❑ work/sports injury
- ❑ fractures/bone disease
- ❑ disc degeneration/ Herniation
- ❑ osteo/rheumatoid arthritis
- ❑ scoliosis
- ❑ osteoporosis

Infectious Diseases
- ❑ tuberculosis
- ❑ HIV/AIDS
- ❑ hepatitis - type:
- ❑ infectious skin conditions
- ❑ other:

Heart/Circulation
- ❑ high blood pressure
- ❑ low blood pressure
- ❑ heart attack/stroke
- ❑ chest pain/angina
- ❑ pacemaker
- ❑ congestive heart failure (CHF)
- ❑ edema/swelling
- ❑ dizziness
- ❑ poor circulation
- ❑ varicose veins
- ❑ phlebitis
- ❑ blood clots
- ❑ B.P: date:

Digestive System
- ❑ constipation/diarrhea/ nausea/vomiting
- ❑ heartburn/indigestion/ gas
- ❑ rapid weight loss
- ❑ appetite changes
- ❑ ulcers
- ❑ jaundice
- ❑ abdominal pain
- ❑ diverticulitis/colitis/ Crohn's
- ❑ irritable bowel syndrome (IBS)

Female
- ❑ menstrual problems – painful/heavy/scant
- ❑ pregnant?
- ❑ menopausal problems

Other
- ❑ diabetes
- ❑ thyroid disease
- ❑ sleep disturbances
- ❑ thoracic outlet syndrome
- ❑ fibromyalgia
- ❑ carpel tunnel syndrome
- ❑ hemophilia
- ❑ cancer
- ❑ other:

An accurate health history is important to ensure that it is safe for you to receive any treatment. If your health status changes in the future, please be sure to let us know. All information gathered for this treatment may be shared with other practitioners of this clinic for treatment purposes; however your information is confidential and will only be released to outside health care professionals or legal representatives upon your written consent. Please be aware that you may request to stop or alter treatment at any time for any reason and the health care professionals will comply with your wishes. **Please note that 24 hours' notice is required to cancel your appointment without charge.**

Consent: I have read and understood the above and give my consent to receive treatment.

Signature: _____ Dated: _____

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Massage Therapy/Acupuncture Informed Consent

In accordance with massage therapy ethics and law, it is necessary to inform the client of any risks associated with massage therapy treatments. Although minimal, with risks having only a slight chance of occurring, they may include, but are not limited to, muscle discomfort, strains and sprains.

Also in the practice of acupuncture there are some risks associated with the treatment. They may include but not limited to, bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, possible perforation of internal organs and stuck or bent needles. Only pre-sterilized needles will be used and these are properly disposed of after each and every treatment.

I understand that if I have not provided a full health history to my therapist and that this could impact my therapist's ability to develop a safe treatment plan for me. I do not expect the therapist to be able to anticipate and explain all possible risks and complication.

I have read the above consent form. I have had the opportunity to discuss with the therapist the nature and purpose of treatments and understand that the results are not guaranteed.

I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

I am able to rescind my consent and stop treatment at any point during the treatment, but must inform the therapist at the moment that I make my decision.

I understand the above statements and accept the risks and hereby consent to treatment.

_____ _____

Signature of Client or Parent/Guardian Date Signed

_____

Print Clients Name