

KING WEST CHIROPRACTIC HEALTH CENTRE

Massage Therapy Health History Form

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: _____ Date: _____
 Tel: res _____
 Address: _____ bus _____
 _____ email _____

Date of birth: _____ Occupation: _____ What is your primary complaint? _____

Who referred you? _____

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

Respiratory	Other Conditions	Women
<input type="checkbox"/> chronic cough	<input type="checkbox"/> loss of sensation	<input type="checkbox"/> pregnant (due: _____)
<input type="checkbox"/> shortness of breath	<input type="checkbox"/> diabetes (onset: _____)	Soft tissue/joint discomfort and its nature
<input type="checkbox"/> bronchitis	<input type="checkbox"/> allergies (ie. anaphylaxis or skin irritation)	
<input type="checkbox"/> asthma	<input type="checkbox"/> epilepsy	<input type="checkbox"/> neck _____
<input type="checkbox"/> emphysema	<input type="checkbox"/> cancer	<input type="checkbox"/> low back _____
Cardiovascular	<input type="checkbox"/> arthritis	<input type="checkbox"/> mid back _____
<input type="checkbox"/> high blood pressure	Head/Neck	<input type="checkbox"/> upper back _____
<input type="checkbox"/> low blood pressure	<input type="checkbox"/> vision problems	<input type="checkbox"/> shoulders _____
<input type="checkbox"/> CCHF	<input type="checkbox"/> vision loss	<input type="checkbox"/> arms _____
<input type="checkbox"/> heart attack	<input type="checkbox"/> ear problems	<input type="checkbox"/> legs _____
<input type="checkbox"/> phlebitis	<input type="checkbox"/> hearing loss	<input type="checkbox"/> knees _____
<input type="checkbox"/> stroke/CVA	Infections	<input type="checkbox"/> other _____
<input type="checkbox"/> pacemaker or similar device	<input type="checkbox"/> hepatitis	What is your general health status? _____
<input type="checkbox"/> heart disease	<input type="checkbox"/> skin conditions	
Skin	<input type="checkbox"/> TB	
<input type="checkbox"/> skin conditions	<input type="checkbox"/> HIV	

Current Medications: _____ Condition it treats: _____	Primary Care Physician: _____ Address: _____
Surgery: _____ date: _____ nature: _____	Present Involvement in Other Health care: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify: _____
Injury: _____ date: _____ nature: _____	_____ _____

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

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

Dear Patient: 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 procedures employed in the clinic.

CLINIC OFFICE POLICY

Clinic Hours: Monday to Friday – 7: 45 am to 6:30 pm

Fee Schedule

<u>Chiropractic:</u>	Fee	Packages:
Initial Examination	75.00	
Subsequent Visit	40.00	12 Visits @ 36.00 x 12 = 432.00 24 Visits @ 34.50 x 24 = 828.00
Student/Senior (Initial Exam.)	55.00	_____
Subsequent Visit	34.00	_____
<u>Acupuncture:</u>	Fee	Packages:
Initial Examination	75.00	
Subsequent Visit	45.00	12 Visits @ 41.00 x 12 = 492.00
Student/Senior	37.00	
Ultrasound Treatment	15.00	_____

Massage Therapy (GST included):

30min treatment	45.00
45min treatment	65.00
60min treatment	85.00
75min treatment	105.00
90min treatment	120.00

**** All prices subject to change.**

Missed Appointments

**At least 24 hours notice is required when cancelling or rescheduling any appointments.
Patients are responsible for the full fee of any missed appointment without 24 hour notice.**

Insurance

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

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.

Patient Signature: _____ **Date:** _____