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.

Clinic Hours

Chiropractic:	Monday to Friday 8:00 am to 6:00 pm
Massage Therapy:	Monday to Friday 9:00 am to 7:00 pm
Osteopathic:	Monday/Wednesday/Friday 10:00 am to 6:00pm

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.

Scent-Free Policy

KWC is a scent-free clinic – please refrain from wearing perfume or cologne.

Massage Therapy and Osteopathy Missed Appointment Policy

24 hours notice is required when
cancelling or rescheduling
massage and 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** ______________________