

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 []	

OFFICE POLICY

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 other clinic procedures.

Clinic Hours: Monday to Friday, 8:00 am to 6:30 pm

Chiropractic Fee Schedule*

Initial Examination (<i>Chiropractic / Acupuncture / Foot Orthotics</i>)	80.00
Adjustment	47.00
Acupuncture	55.00
One pair of Custom Foot Orthotics	490.00
Second pair of Custom Foot Orthotics (<i>if ordered on the same day</i>)	290.00
One pair of Orthotic Shoes	570.00

Massage Therapy Fee Schedule*

30 min treatment	60.00 + <i>hst</i>
45 min treatment	75.00 + <i>hst</i>
60 min treatment	96.00 + <i>hst</i>
75 min treatment	119.00 + <i>hst</i>
90 min treatment	140.00 + <i>hst</i>

Osteopathy Fee Schedule*

55 min initial treatment	140.00
40 min subsequent treatment	110.00

**All rates subject to change.*

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.

Massage Therapy and Osteopathy Missed Appointment Policy

24 hours notice is required when canceling or rescheduling massage/osteopathic appointments.

If we are unable to fill the timeslot patients will be responsible for the full fee of the missed appointment.

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

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 _____