



# Kay • Harris Chiropractic & Wellness Centre

## CONFIDENTIAL HEALTH HISTORY

The information requested below will help assist us in treating you safely. If your health status changes, please notify your Registered Massage Therapist. Please note that all information provided below will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Date of Birth: (M)\_\_\_\_(D)\_\_\_\_(Y)\_\_\_\_  
Occupation: \_\_\_\_\_

Today's Date: \_\_\_\_\_  
Phone (h): \_\_\_\_\_  
Phone (c): \_\_\_\_\_  
Phone (w): \_\_\_\_\_  
E-Mail: \_\_\_\_\_

Family Physician: \_\_\_\_\_  
Physician Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Date of Last Massage: \_\_\_\_\_

What brings you in for massage?

Relaxation    Stress    Injury    Pain

Please check any conditions you are experiencing or have experienced:

### CIRCULATION

- HIGH BLOOD PRESSURE
- LOW BLOOD PRESSURE
- HEART CONDITION
- HEART ATTACK  STROKE
- VARICOSE VEINS / PHLEBITIS
- PACEMAKER
- POOR CIRCULATION
- DIZZINESS

### RESPIRATORY

- CHRONIC COUGH
- SHORTNESS OF BREATH
- BRONCHITIS
- ASTHMA
- EMPHYSEMA

### WOMEN

- PREGNANT-DUE: \_\_\_\_\_
- PMS
- MENOPAUSE

### GENERAL

- LEFT HANDED
- RIGHT HANDED

### IMMUNE SYSTEM

- HEPATITIS

- TUBERCULOSIS (TB)
- HIV/AIDS
- ALLERGIES
- SKIN CONDITIONS  
TYPE: \_\_\_\_\_
- BRUISE EASILY

### MUSCLES/JOINTS

- ARTHRITIS
- BURSITIS/TENDONITIS
- FRACTURES
- WHIPLASH       TMJ
- NECK PAIN
- BACK PAIN - AREA: \_\_\_\_\_
- STIFF/SWOLLEN JOINTS
- POOR POSTURE
- FOOT/ KNEE/ LEG PAIN
- ARM / HAND PAIN

### GASTROINTESTINAL

- CONSTIPATION / DIARRHEA
- LIVER/GALL BLADDER
- ULCERS
- NAUSEA/ HEARTBURN/ GAS

### OTHER CONDITIONS

- HEADACHES / MIGRAINES
- VISION/ HEARING PROBLEMS
- LOSS OF SENSATION

- DIABETES - TYPE: \_\_\_\_\_
- HYPOGLYCEMIA
- EPILEPSY
- CANCER
- SCIATICA
- ARTIFICIAL JOINTS
- INTERNAL PINS
- SPECIAL EQUIPMENT

### CURRENT MEDICATIONS & CONDITIONS

\_\_\_\_\_  
\_\_\_\_\_

### PAST SURGERY / INJURY DATE

\_\_\_\_\_  
\_\_\_\_\_

### OTHER HEALTHCARE

- CHIROPRACTOR
- PHYSIOTHERAPY
- OTHER: \_\_\_\_\_



# Kay • Harris Chiropractic & Wellness Centre

## CANCELLATION POLICY

Kay Harris Chiropractic and Wellness Centre has established the following missed or late cancellation policy:

It is important that you be punctual for your appointment so you may benefit from the full time slot reserved for your treatment. If you are unable to keep your appointment, please advise us 4 hours in advance to avoid a \$40.00 late cancellation fee. We appreciate and thank you for your understanding.

## CONSENT FOR TREATMENT

I have been informed and understand the purpose of the assessment and the related benefits of treatment, as well as the possible risks and side effects. I have had the opportunity to ask any questions regarding the assessment during the visit, as well as the treatment and any alternative. I understand that I have the right to have the therapist modify or stop the assessment/ treatment at any time.

I understand that all my records will be kept confidential and will not be released without my written consent. I give consent to all practitioners at Kay Harris Chiropractic and Wellness Centre to read, share and discuss my personal medical history while I am a patient at Kay Harris Chiropractic and Wellness Centre.

I am aware that a missed or cancelled appointment without 4 hours notice will result in a \$ 40.00 charge.

I consent to the assessment / treatment / cancellation policy as prescribed by my massage therapist.

\_\_\_\_\_  
Name: Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient / Legal guardian

## CONSENT FOR TREATMENT OF SENSITIVE AREAS

Some medical conditions require treatment to sensitive areas; gluts, medial thigh, breast or abdomen. If indicated and recommended by your massage therapist, please read and sign below.

I consent to massage therapy for gluts, medial thigh, breast and/or abdomen as recommended by my massage therapist. Techniques, draping, effects and risks have been explained to me. I am aware of my right to have my therapist modify my treatment or withdraw my consent at any time.

\_\_\_\_\_  
Name: Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient / Legal guardian