Ottawa Chiropractic Health Clinic

Karim Ali RMT

200 Kent Street, Ground Floor • Ottawa, ON, K2P 2J8 • Tel: (613) 233-8700

Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or requested by law. Your written permission will be required to release any information.

Last Name: _____ • First Name: _____

Address: _____ Town/Prov.: _____ Postal Code: _____

Date of Birth: Day ( ) Month ( ) Year ( ) • Age: _____

Tel. (Home): (_____) _____-_____ • (Work): (_____) _____-_____ Ext: _____

(Cell): (_____) _____-_____ • E-mail: _____

❑Yes, you may send me e-mail reminders, statements and clinic changes ❑No, do not contact me by e-mail

Occupation: _____

How did you hear about us? _____

Have you received massage therapy before? YES ○ NO ○

Did a health care practitioner refer you for a massage therapy? YES ○ NO ○

If yes, please provide their name and address:_____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
- ○ High blood pressure
- ○ Low blood pressure
- ○ Chronic congestive heart failure
- ○ Heart attack
- ○ Phlebitis
- ○ Stroke/CVA
- ○ Pacemaker or similar device
- ○ Heart disease

Is there a family history of any of the Above? YES ○ NO ○

Respiratory
- ○ Chronic cough
- ○ Shortness of breath
- ○ Bronchitis
- ○ Asthma
- ○ Emphysema

Is there a family history of any of the above? YES ○ NO ○

Infections
- ○ Hepatitis
- ○ Skin conditions
- ○ TB
- ○ HIV
- ○ Herpes

Other Conditions
- ○ Loss of sensation

Where? _____
- ○ Diabetes, onset:_____
- ○ Allergies/Hypersensitivity

To what? _____

Type of reaction? _____
- ○Epilepsy
- ○ Cancer_____
- ○ Skin Condition

What? _____
- ○Arthritis

Is there a family history of Arthritis? YES ○ NO ○

Head/Neck
- ○ History of headaches
- ○ History of migraines
- ○ Vision problems
- ○ Vision loss
- ○ Ear problems
- ○ Hearing loss

Women
- ○ Pregnant? YES ○ NO ○

Due date:_____
- ○ Gynaecological conditions

What? _____

Overall, how is your general health?

_____

Primary Care Physician:

_____

Address:

_____

_____

Current Medications:_____

Condition it treats:_____

Are you currently receiving treatment from another health care professional YES ○ NO ○

If yes, for what? _____

_____

Surgeries

Date:_____ Nature:_____

Date:_____ Nature:_____

Injuries

Date:_____ Nature:_____

Date:_____ Nature:_____

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) YES ○ NO ○ What? _____

Do you have any internal pins, wires, artificial joints or special equipment? YES ○ NO ○

What? _____

Where? _____

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort

_____

_____

Notes:

Date of initial Health History:_____

Update 1:_____

Update 2:_____

Update 3:_____

Update 4:_____

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Informed Consent for Massage Therapy

Massage Therapy care is based on promoting health, preventing illness and helping individuals attain and maintain the highest levels of wellness possible by integrating the art and science of Massage Therapy through responsible, compassionate, and respectful touch.

The value of nurturing touch during the delivery of Massage Therapy is a well established and vital element. The therapist acknowledges all facets of their clients being, including their physical, emotional, mental and spiritual aspect.

Your comfort and trust in this clinic is very important in providing an optimal client/therapist relationship. Before, during, or after therapy, we encourage you to communicate to the therapist about any aspect of treatment.

Treatment will be provided only when there is reasonable expectation that it will be advantageous to the client.

Proper draping is always provided to ensure safety, comfort and privacy for all clients. Clients are asked to disrobe in privacy and prepare themselves on the table. You may choose to remove or leave clothing on, according to your own comfort level. Treatment will be modified to accommodate this. The Massage Therapist respects your right to modify, refuse or terminate treatment, regardless of prior consent given.

The Massage Therapist respects the client's right to an informed and voluntary consent regarding care and treatment and to obtain consent of the client before providing treatment. This clinic respects the confidentiality of all client information, unless disclosure is required by law or court order. Information will not be released otherwise, unless a client's written consent is obtained.

Cancellation Policy

Your care is very important to this office and as a result, an appointment time is reserved for your treatment. If necessary to reschedule or cancel an appointment, please attempt to provide our office with 24 hours notice. However, please also note the following

- An appointment cancelled within 3 hours of scheduled treatment will be subject to an administration fee of $15.00. However, should you reschedule your appointment within 7 days, this fee will be waived.
- Should you miss an appointment, you will be subject to the full cost of the treatment.

I, _____ have read the above information and understand my rights to consent of treatment.

Signature: _____ • Date: _____