HEALTH STATUS FORM

All Documentation is kept CONFIDENTIAL and will not be disclosed without your written consent.

Therapist's Name: ____________________________

How did you hear about us? ________________________________

NAME: ____ DATE: ________________________

Street Address ____

City: _______________________________________ Province __________ Postal Code ______________

Email: ____

Tel.# Home: ________________________________ Tel.# Cell: _______________________________

Tel.# Work: _________________________________ Occupation: _____________________________

Date of Birth: _______________________________ Age: _______ Sex: M / F # of Children: ______

Insurance: ____

Family Doctor: ____ Tel.#: _____________________

Have you ever received massage therapy? **Yes / No** If yes, when? ______________________________

Have you ever received acupuncture? **Yes / No** If yes, when? ______________________________

REASONS FOR SEEKING THERAPY? ____

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Other Complaints: ____

Aggravating factors: ____

Relieving factors: ____

Job related concerns: ____

Previous / Current treatments from other health professionals? If yes, give details: __________________

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Chiropractor: __________________________ Physiotherapist: ______________________________

Naturopath: ___________________________ Others: ____________________________________

Current Medications and Supplements (including Amounts and Frequency): ________________________

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Reason: ____

Surgeries: ____

Year(s): ____

Pregnancies: ________Complications: ____

Do you exercise? ____ How often? ____

What activity? ____

Accidents and Major Injuries: What happened? When? Treatment received? _____________________

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Allergies: Foods: ________________ Scents: __________________ Others: ______________________

Diet: How much coffee do you drink? ___________ Pop? ____________________ Water? ___________

How is your sleeping pattern? ____________ How many hours of sleep do you get? _________________

Height: ___________________ Weight: _________________ BMI: ____________________

Please √ if you <u>have</u> any of the following conditions or ○ you <u>had</u> any of them in the past

RESPIRTATORY
- ❑ Emphysema
- ❑ Bronchitis
- ❑ Sinus problems
- ❑ Shortness of breath
- ❑ Smoking (quantity:_________________)
- ❑ Asthma
- ❑ Cough

DIGESTION
- ❑ Constipation
- ❑ Diarrhoea
- ❑ Liver disease
- ❑ Gallbladder
- ❑ Ulcers
- ❑ Colitis
- ❑ TMJ dysfunction/pain
- ❑ Eating disorder
- ❑ IBS
- ❑ Gas/Bloating
- ❑ Weight problems
- ❑ Crohn's disease
- ❑ Diverticulitis

OTHERS
- ❑ Addictions
- ❑ Cancer ________________
- ❑ AIDS/HIV
- ❑ Hepatitis
- ❑ Chicken pox/Shingles
- ❑ Tuberculosis
- ❑ Cysts
- ❑ Diabetes
- ❑ Hypo/Hyperglycaemia
- ❑ Thyroid dysfunction
- ❑ Urinary problems
- ❑ Other conditions

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CARDIOVASCULAR
- ❑ Poor circulation
- ❑ Heart attack
- ❑ High/Low Blood Pressure
- ❑ Heart disease
- ❑ Heart palpitations
- ❑ Stroke
- ❑ Pacemaker/Defibrillator
- ❑ Blood Clots
- ❑ Varicose Veins
- ❑ Phlebitis
- ❑ Swelling Ankles
- ❑ Haemophilia
- ❑ High Cholesterol

NERVOUS
- ❑ Depression
- ❑ Headaches
- ❑ Migraines
- ❑ Paralysis
- ❑ Stress
- ❑ Insomnia
- ❑ Alzheimer's
- ❑ Chronic Fatigue Syndrome
- ❑ Epilepsy
- ❑ MS
- ❑ Parkinson's
- ❑ Vision problems
- ❑ Contact Lenses
- ❑ Hearing problems

FEMALE
- ❑ Pregnancy (currently)
- ❑ TVF Procedures
- ❑ Hysterectomy
- ❑ Painful menstruation
- ❑ IUD
- ❑ Menopause
- ❑ Breast pain
- ❑ Breast lumps
- ❑ PMS
- ❑ Endometriosis

SKIN
- ❑ Sensitive Skin
- ❑ Open sores
- ❑ Rash
- ❑ Cold sores
- ❑ Bruises easily
- ❑ Athlete's Foot
- ❑ Warts
- ❑ Atypical Moles
- ❑ Acne
- ❑ Eczema
- ❑ Psoriasis
- ❑ Hot/Cold sensitivity
- ❑ Cellulitis
- ❑ Scars ________________
- ❑ Skin Cancer
- ❑ Schleroderma
- ❑ Lupus

MUSCULOSKELETAL
- ❑ Arthritis

Type/Location: ____________
____
- ❑ Osteoporosis
- ❑ Head Injury
- ❑ Pins/Implants
- ❑ Artificial joints
- ❑ Prosthesis/Orthotics
- ❑ Disc Injury
- ❑ Tendinitis
- ❑ Bursitis
- ❑ Sprain
- ❑ Strain
- ❑ Muscle Spasm
- ❑ Muscle Stiffness
- ❑ Fibromyalgia
- ❑ Myofascial Pain
- ❑ Painful/Limited movement
- ❑ Disability _____________

OTHERS not listed:

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Please read carefully before signing as the terms below are aimed at providing you with safe and effective massage therapy and acupuncture services and are outlined for both your protection as well as the protection of Myoflex Massage & Rejuvenation Clinic herein referred to as the clinic.

CONSENT FOR TREATMENT

By signing below you acknowledge the consent for treatment terms as follows:

- Your consent to receiving massage therapy and acupuncture.
- Prior to treatment the benefits and risks of proposed treatment will be explained.
- Your obligation to inform the therapist of any pain or discomfort during or after the treatment.
- The health status form is filled out to the best of your knowledge and is an accurate representation of you medical and psychological status.

CLINIC POLICY

By signing below you acknowledge our clinic policy as follows:

- If unable to keep your appointment please give 24 hours notice.
- We may charge a fee for any missed appointments without any given notice.
- We accept cash, debit, Visa, and MasterCard payments for our services.
- We expect payment upon completion of treatment unless other arrangements have been made.
- There will be a $20.00 charge for any NSF cheques.
- We grow by referrals; please ask about our referral policy.

CONSENT REGARDING PERSONAL INFORMATION

By signing below you acknowledge the terms regarding your personal information as follows:

Please check the boxes below to receive the following:

- ☐ **Reminders or notifications of changes to your appointments** by telephone, including messages left at home, cell phone or at work.

- ☐ **Email, newsletters, or other informational mail outs** including promotional or special offers.

I understand that in order to provide safe and effective massage or acupuncture treatments, Myoflex Massage & Rejuvenation Clinic needs to collect health information which may only be used, in whole or in part, in the process of corresponding with my physician, insurance company or lawyer, as required. I have been given a chance to ask any questions I had and they have been answered to my satisfaction. I hereby give consent to Myoflex Massage & Rejuvenation Clinic to collect, use and disclose personal information about me as set out above.

PRINTED NAME: ____

SIGNATURE: ______________________________ DATE: ________________

NOTES: ____

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