HEALTH HISTORY FORM

How did you hear about our clinic?
Yellow Pages _____Website _____Our sign_____ Facebook_____Other?_____
Family/Friend/Co-Worker___ WHO?_____
Permission to acknowledge the person who referred you_____(Initials)

Name:_____ Date:_____
Address:_____ Telephone:(Home)_____
City:_____ Postal Code:_____ (Cell)_____
(Work)_____
Occupation:_____ Company:_____
Email Address:_____ Date of Birth(mm/dd/yy)_____
Emergency Contact:_____ Telephone:_____
Do you have Extended Health Care Insurance Coverage for Massage Therapy? □ Yes □ No

Doctor's Name:_____Telephone #:_____
Permission to consult with your Doctor: □ Yes □ No Initials:_____

Primary Complaint?_____ Aggravates/Relieves?_____
Have you seen a Doctor for this problem? □ Yes □ No When?_____
Overall, how is your general health?_____

Please indicate conditions you are experiencing or have experienced:

Respiratory
- □ Chronic Cough
- □ Shortness of Breath
- □ Sinus Problems
- □ Emphysema
- □ Asthma
- □ Allergies
- □ Other_____

Cardiovascular
- □ High/Low Blood Pressure
- □ Blood Clots
- □ Heart Disease/Heart Failure
- □ Myocardial Infarction
- □ Stroke/CVA
- □ Pacemaker or similar device
- □ Other_____

Digestive
- □ Constipation/Diarrhea
- □ Gas/Bloating
- □ IBS
- □ Other_____

Nervous System
- □ Herpes/Shingles
- □ Numbness/Tingling

  Where?_____
- □ Chronic Pain
- □ Loss of Sensation

  Where?_____
- □ Other_____

Musculo-Skeletal
- □ Bone or Joint Disease
- □ Arthritis-Type_____

  Family Hx:_____
- □ Tendonitis
- □ Bursitis
- □ Sprains/Strains
- □ Low back/Hip/Leg pain
- □ Neck/Shoulder/Arm pain
- □ Jaw Pain/TMJ
- □ Other:_____

Reproductive
- □ Pregnant
- □ Due Date:_____
- □ Gynaecological:_____

Other
- □ Hepatitis
- □ Depression
- □ Diabetes-Type_____
- □ Vision/Hearing Loss
- □ Headaches/Migraines
- □ Epilepsy
- □ Kidney Disease_____
- □ Other:_____

Infections:
- □ Allergies- _____
- □ TB
- □ HIV/AIDS
- □ Other:_____
- □ Eczema/Psoriasis

Skin
- □ Bruise Easily
- □ Allergy to creams/lotions
- □ Athletes Foot
- □ Warts
- □ CFS/Fibromyalgia
- □ Other:_____
- □ Cancer-_____

Please turn over and complete other side⇒

Current Medications, Vitamins, Herbal Remedies & Conditions they treat:
Name:_____ Condition:_____
Name:_____ Condition:_____
Name:_____ Condition:_____
Name:_____ Condition:_____

Surgeries and Approximate Date:
Surgery:_____ Date:_____
Surgery:_____ Date:_____
Surgery:_____ Date:_____

Motor Vehicle Accidents and Date
Accident & Injuries:_____ Date:_____
Accident & Injuries:_____ Date:_____

Other Accidents and Injuries:_____ Date:_____
Presence of Internal Pins, Wires, Artificial Joints, Special Equipment, Etc.:_____

Other Therapies (Massage Therapy, Chiropractic, Physiotherapy etc.):_____

Do you have any other conditions not listed or is there anything about yourself you feel would be important for your Therapist to know:_____

Please check the body parts you consent to be treated:
Head/Face___ Neck___ Shoulders/Arms___ Hips___ Legs___ Buttocks___ Abdomen___ Inner Thigh___Back____

Consent Form:

It is important that you fill out this health history form to ensure that it is safe for you to receive treatment. If your health status changes please notify your therapist before your next treatment. All information gathered will be kept confidential except as required by law or to facilitate an assessment or treatment. Written authorization from you will be required before any information is released.

I agree to communicate with my therapist at any time if I have questions, if I feel uncomfortable, or if I feel my well-being is being compromised. I will give consent to my massage therapist to treat only on the areas of my body we discussed in the treatment plan. This may include sensitive areas such as gluteals/buttocks, breast/chest wall and upper inner thigh, if necessary. **Initials**_____

I am aware that I may remove only the clothing that I am comfortable removing. I know that I have the right to stop or modify the treatment at any time. It is my choice to receive massage therapy. I understand that Registered Massage Therapists do not diagnose illness, disease or any mental or physical disorder; nor do they prescribe medical treatment or pharmaceuticals. **Initials**_____

Cancellation Policy:
There will be a 50% cancellation fee applied to any missed appointments or appointments cancelled with less than 24 hrs. notice (not illness related)
Our late cancellation fee will be waived if you cancel due to illness or suspected illness. We would prefer to reschedule your appointment if you are ill. Please try to give our office appropriate notice.

Signature:_____ **Date:**_____
Parent/Guardian Signature:_____ **Date:**_____
(if under 16 years of age)

Permission Form:

I, _____ give permission for the clinic of Niagara Therapeutics Inc.to send informational material via mail or email. Personal Information collected by the clinic will not be used for any other purposes. ☐ Yes ☐ No Appointment reminder emails. . ☐ Yes ☐ No
My email address is:_____
Signature:_____Date:_____

For office use only:
History:_____
Update 1:_____ Update 2:_____Update 3:_____

Covid-19 Question Check List (According to Ontario Government Document)

Niagara Therapeutics Screening Questions:

1. Is the client presenting with fever, new onset of cough, worsening chronic cough, shortness of breath, or difficulty breathing? **[ ] Yes/ [ ] No**

2. Did the person have close contact with anyone with acute respiratory illness or travelled outside of Canada in the past 14 days? **[ ] Yes/ [ ] No**

3. Has the client had/have a confirmed case of Covid-19 or had close contact with a confirmed case of Covid-19? **[ ] Yes/ [ ] No**

4. Does the person have two (2) or more of the following symptoms (Sudden onset: Not including if persistent over the last 6 months)

   [ ] Sore throat [ ] Runny nose/sneezing [ ] Nasal congestion [ ] Hoarse voice

   [ ] Difficulty swallowing [ ] Decrease or loss of sense of smell [ ] Chills

   [ ] Headaches [ ] Unexplained fatigue [ ] Diarrhea [ ] Abdominal pain

   [ ] Red eyes [ ] Nausea [ ] Vomiting

5. If the person is over 65 years of age, are they experiencing any of the following; [ ] Delirium [ ] Falls [ ] Acute functional decline [ ] worsening of chronic conditions.

6. I _____(Print name), understand that while Niagara Therapeutics have taken extreme measures to minimize risk of transmission; Just to list a few thing that will be implementing;
   > Increased cleaning protocols throughout the clinic
   > Each treatment room will be fully disinfected after each treatment.
   > Therapist to wear a new pair of gloves with each treatment
   > Therapist to wear a mask while in the clinic at all times.
   > Therapist to wear a new pair of scrubs with each treatment provided
   > Washroom is to be full cleaned after each use

The nature of Massage Therapy or Osteopathy makes it not possible to maintain physical distancing while in the treatment room. Please sign if you consent to treatment.

Name Sign:_____

Date:_____

Turn over: Page 1/2

7. Consent to have forehead temperature take before treatment. Please sign.

I,_____(name), give consent to have my body temperature taken by an infrared forehead thermometer. This temperature will be recorded before each treatment in accordance with Covid -19 guidelines. The thermometer is sanitized between each use according to public health guidelines. Niagara Therapeutics has the right to refuse treatment if a fever is indicated.

Client signature:_____

Date:_____