Clinic	**Health History form**

In accordance with provincial privacy legislation we need to obtain your informed consent regarding the collection, use and disclosure of personal information (including health information). The purposes for which we collect, use and disclose such information are set out in this form and in our Privacy Policy. If you have any questions please do not hesitate to ask.

CONSENT FOR COLLECTION OF PERSONAL INFORMATION

I understand that to provide me with safe and effective treatments, The therapist will collect some personal information about me(e.g., personal contact info, health history information).

I have had the opportunity to review the clinic's/therapist's privacy policy about the collection, use and disclosure of personal information, steps taken to protect personal information, and my rights regarding accessing and collecting my personal information.

I understand that I can refuse to sign this consent form. I can also withdraw my consent at any time by writing to the clinic or Therapist. Without access to the information requested on this form, however, unfortunately we cannot offer you treatment.

I agree to the clinic/Therapist collecting, using and disclosing personal and health information about me(including with my health care team) as set out in its privacy policy.

SIGNATURE:_____ DATE:_____

Name: **Phone #:**

Address: **Postal**

Occupation:

Date of Birth:
E-mail:

What brings you in for a □ Massage □Reflexology therapy?

Primary Care physician:
Phone #:

Address:

Date of last doctor visit:

Who referred you to us?

Current medication (Include topicals, hormonals)

Drug name	Used for	Special Considerations
1	1	□Pacemaker □Artificial joint
2	2	□Artificial valve □Artificial limb(s) □med patch □Crutch use
3	3	□Rods,pins,wires □Cane, walker □Chemo or drug port □wheelchair
4	4	□breast implants □other:

May we contact you to inform you about promotions, updates and also for special events.
□ Via email □ via mail □ no thanks

Please indicate conditions you are experiencing or have experienced below

Respiratory
□ Chronic cough
□ Asthma
□ Bronchitis
□ Emphysema
□ Other

Cardiovascular
□ High blood pressure
□ Low blood pressure
□ Congestive heart failure
□ Heart attack
□ Phlebitis / Varicose veins
□ Stroke / CVA
□ Pacemaker
□ Other:

Central Nervous System
□ Epilepsy
□ TIA/stroke
□ Multiple Sclerosis
□ Parkinsonism

Infectious conditions:
□ HIV / AIDS
□ Hepatitis Type ….
□ TB
□ Other

Digestive System
□ Constipation
□ Crohn's disease
□ Kidney disease
□ Prostate problems
□ Recurrent Infection
□ Irritable Bowel Syndrome
□ Other:

Skin
□Infectious Condition
□Warts, Herpes
□Eczema
□Psoriasis
□Other:

Is there a family history of any of the above: □ Yes □ No

□ **Altered sensation**
Where?

□ **Arthritis** type?
where?

□**Cancer C=current P=past**
Type?
Year diagnosed:
Chemotherapy □C □P
Radiation □C □P
Current complications?

□**Diabetes**, Type 1 2
Current complications:

year diagnosed:

□ **Allergies**
□Nuts □Herbs
□Oils, Creams, Lotions
□Aromas, Airbone
□Latex □Drug Allergy
□History of Anaphylaxis
□other:

□ **Visual** impairment
□ **Hearing** impairment

Musculoskeletal issues

	Past	Current
Neck	□	□
Shoulder	□	□
Arm	□	□
Wrist	□	□
Hands	□	□
Upper back	□	□
Mid back	□	□
Low back	□	□
Hip	□	□
Knee	□	□
Ankle	□	□
Foot	□	□

Surgeries

	Type	Year
1		
2		
3		

Current complications:

Injuries

	Type	Year
1		
2		
3		

Current complications:

□**Headaches** Type?

Where?

Other Health care

	Past	Current
Physiotherapy	□	□
Chiropractic	□	□
Naturopathy	□	□
Psychotherapy	□	□
Medical specialist	□	□

Other:

Women
□ Pregnant? Due:
□ High risk pregnancy
□ Endometriosis
□ Breast pain
□ Breastfeeding
□ Menstruation Issues
□ Menopause Issues
□ Other

Life style
□Regular exercise
Types?

Diet
Eating habits □Good □Not good
Stress Levels □High □Med
Water consumption per day: