Durham's Cloud Nine Massage Therapy

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Health History Form

The information of this form is confidential and will be used by the therapist to facilitate care planning and the implamentation of massage therapy. Feel free to ask any questions about the information being requested. Your information is kept confidential unless allowed or required by law. Your written permission will be required to release any infomation. Should your health history change, it is your responsibility to inform the therapist to update the form.

Signature Name Today's Date

Address

Apt# City Province Postal Code

Occupation Date of Birth Telephone ( ) Home

Where did you hear about the clinic? Telephone ( ) Work/Cell

Major Area of Concern/Complaint General Health Status:

Doctor Address:

Clinical Data

Height Pulse Age

Weight Blood Pressure

Health History:Please check all the conditions that you're currently experiencing or have experienced in the past

	Current	Previous
Head/Neck		
Head Ache:		
Vision Problems		
Ear aches		
Sinus		
Respriatory		
Chronic Cough		
Shortness of Breath		
Bronchitis		
Asthma		
Emphysema		
Cardiovascular		
High Blood Pressure		
Low Blood Pressure		
Poor Circulation		
Heart Disease		
Phlebitis		
Stroke		
Myocardial Infarction		
Varicose Veins		
Chronic Congestive Heart Failure		
Pace Maker		
Infections		
Hepatitis		
TB		
HIV, AIDS		
Skin		
Skin Conditions Type:		
Women		
Menstraul Problem		
Cesarean Section		
Pregnant		
Due Date (DD/MM/YY)		
Menopausal		

	Current	Previous
Other Conditions		
Difficulty Digesting		
Constipation		
Diabetes Type 1		
Type 2		
Hypoglycemia		
Epilepsy		
Insomnia		
Cancer		
Arthritis		
Fibro-myalgia		
Urinary Disorders		
Hemphilia		
Loss of Senstion		
Hearing Loss		
Allergies		
Muscle / Joints / Soft Tissue Pain / Stiffness		
Neck		
Shoulder		
Upperback		
Mid-back		
Lowerback		
Leg L / R		
Knee L / R		
Other:		
Other Medical Condtions		
Other Health Care		
Chiropractic		
Physiotherapy		
Medic Alert Chain/Bracelet Y / N		

CURRENT MEDICATIONS

Name For What Condition?

SURGERY

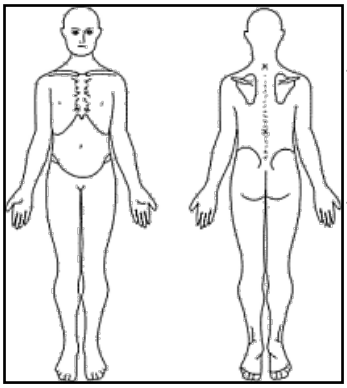
INJURY including motor vehicle accident

FAMILY HEALTH INFORMATION

Some health problems are heredity or familial. Information about your family may be helpful in assessing your current condition.

OF SPECIAL NOTES

(pins, wires, plates, artificial joints or limbs, special equipment: wheelchair, walker, cane, dentures, glasses, contact lenses, hearing aid)



Please circle the area(s) which cause(s) you the greatest amount of discomfort on the diagram.

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I am grateful to have such wonderful clientele who value my work and respect my time. To avoid any misunderstandings, I ask that you take a moment now to read my office policies. Please speak with me, if you have any questions or concerns regarding these policies.

CANCELLATION POLICY

When you book an appointment, please be aware that you have reserved your therapist's time. To cancel an appointment or reduce the duration of a session I require a MINIMUM of 24 hours' notice.

I always appreciate more time if you are able to provide it. Without proper notification, you are responsible for payment of the full appointment fee. Of course I understand that there will be rare cases when emergencies make it impossible to give the full 24 hours' notice. In the case of therapist illness, injury or family emergency, I will give you as much notice as possible, and do my best to provide an appointment as soon as possible.

In the case of last minute cancellations, I will try my best to rebook your appointment. If I am able to do so, I will waive last minute cancellation fees, so please give me as much notice as possible. Keep in mind the increased stress and work involved in trying to fill appointments last minute.

The College of Massage Therapists of Ontario requires that any receipt supplies for payments of cancellation fees clearly state "No Show or Last Minute Cancellation Fee Payment".

RECIPT POLICY

1 The name on the receipt will be the same name as the person receiving the treatment.
2 The date on the receipt will be the same as the date that the treatment was performed.
3 The amount on the receipt will be the same amount as the services performed.
4 Any re-issue of a receipt will say COPY
5 If modalities other than massage are performed that modality will be written on the receipt.
6 The name on the receipt will be the name of the person who purchased the gift certificate and will read gift certificate purchased. Receipts are only allowed to be issued when money is exchanged. If your loved one has massage coverage we suggest that instead of paying us ahead, that you simply book their appointment and make arrangements to pay the same day of that appointment.

RUNNING LATE

I will try my best to let you know when I am running late (15 min. or more). My appointments are scheduled with 30 minute between appointments to maintain a relaxed and professional setting and to allow me to arrive at other appointments. I suggest that you allow for open time before and after your sessions to reduce stress and enhance the therapeutic value of your treatment.

1 If you arrive late for your appointment, time may not allow for your therapist to accommodate all of your treatment time. However, I reserve the right to charge for the full treatment time.
2 If your therapist is running late and you are unable to have your full treatment time, you will be charged only the amount of time that the therapist was able to treat.

By signing below I am agreeing to the policies listed above and agreeing that I have disclosed all my medical health history to the best of my knowledge

Date: _____Print Name:_____ Signature:_____

Update 1:_____Update 2:_____Update 3:_____

I value your patronage and look forward to being an integral part of your health and wellness program.