ZAWADA HEALTH

HEALTH HISTORY FORM

Please complete this form in full. All information is strictly confidential. Please print.

Date:_________________________

Name:____ Age:_________ Male / Female
LAST FIRST

Address:____
Street CITY PROVINCE

Postal Code:_______________ Date of Birth:___________________________
DAY / MONTH / YEAR

Telephone: HOME_____________________ WORK______________________ E-MAIL:_______________________

Employer: _____________________________________ Occupation:________________________________

How did you hear from us:________________________________ Date of last examination:_________________
DAY / MONTH / YEAR

Primary Care Physician (Medical Doctor):_________________________________ Tel:_____________________

Emergency Contact: ____
FULL NAME TELEPHONE

Have you ever received Chiropractic Care before? ☐ Yes ☐ No If Yes, When? __________________________

Have you ever received Massage Therapy before? ☐ Yes ☐ No If Yes, When? __________________________

Spinal X-rays Available? ☐ Yes ☐ No If Yes, When taken? __________________________

List any past surgery and any surgical implant (pins, artificial joint, metal plates, pacemaker, etc)

List any past injuries / accident:

List all medications you are currently taking, or have taken within the past 6 months, and the reason for taking:

Are you undergoing any form of treatment? Please detail:

Do you exercise regularly (i.e. 3 times per week)? YES / NO
If YES what do you do?:____

WOMEN:
Are you pregnant? YES / NO If YES what trimester:________________ Due Date:_________________
Date of last menstrual cycle:______________________

List any problems / discomfort you are experiencing due to the pregnancy:

Please indicate conditions you are experiencing, or have experienced:

RESPIRATORY
- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma / allergies __________________
- ☐ emphysema

CARDIOVASCULAR
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ heart attack
- ☐ phlebitis (swollen vein)
- ☐ stroke /CVA
- ☐ pacemaker or similar device
- ☐ rapid heart beat
- ☐ chest pain
- ☐ cold feet/hands

OTHER CONDITIONS
- ☐ skin condition (Precise:_________________)
- ☐ endometriosis
- ☐ diabetes (Onset:______________________)
- ☐ epilepsy
- ☐ cancer (Precise:______________________)
- ☐ bruise easily
- ☐ hernia (where________________________)
- ☐ anemia
- ☐ blood related (Precise:__________________)
- ☐ hemophilia
- ☐ arthritis OA / RA / GOUT ?
- ☐ lupus
- ☐ fibromyalgia
- ☐ fever
- ☐ diarrhea/constipation

MUSCLE / JOINT / SPINE
- ☐ neck pain/stiffness
- ☐ low back pain
- ☐ mid back pain
- ☐ upper back pain
- ☐ shoulders Right / Left
- ☐ arms Right / Left
- ☐ legs Right / Left
- ☐ knees Right / Left
- ☐ pins/needles - arms/legs
- ☐ numbness - fingers/toes
- ☐ other (Precise:________________)

HEAD / NECK
- ☐ headaches
- ☐ light bothers eyes
- ☐ dizziness / loss of balance / fainting
- ☐ vision problems _______________
- ☐ vision loss
- ☐ ears ringing/buzzing
- ☐ hearing loss

INFECTIONS
- ☐ hepatitis
- ☐ skin condition (explain__________)
- ☐ bladder / kidney
- ☐ TB
- ☐ HIV

OTHER
- ☐ sleeping problems
- ☐ nervousness
- ☐ tension/stress
- ☐ irritability
- ☐ loss smell / taste
- ☐ fatigue / depression
- ☐ loss of memory
- ☐ significant weight loss

Please list any other medical condition you might have that is not listed:

What is your chief complaint?

I certify that the information given in this form is true and accurately reflects my past and present health status.
I understand that I am receiving treatment from a Registered Massage Therapist.
**Please also sign the “consent to treatment” form.

Signature:_______________________________________ Date:___________________________

ZAWADA HEALTH

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the Massage Therapist is providing massage therapy services within their scope of practice as defined by the College of Massage Therapists of Ontario, Inc.

I hereby consent to my Therapist to treat me with Massage Therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my Therapist.

I acknowledge that the Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that Massage Therapy is not a substitute for a medical examination. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the Therapist must be fully aware of my existing medical conditions. I have completed my medical history form, as provided by my Therapist, and have disclosed to the Therapist all of those medical conditions affecting me. It is my responsibility to keep the Massage Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I understand that because of the nature of Zawada Health, patient files and subsequently information contained in files is shared among practitioners for the mutual benefit of patient treatment. I understand that written consent must be obtained for a practitioner to remove/transfer file information outside of Zawada Health.

I understand that **any sexual comments, innuendos or contact will not be tolerated at any time.** The therapist reserves the right to terminate the treatment immediately and charge the full fee to violators.

I understand that failure to provide 24 hours' notice prior to cancelling an appointment will result in a charge of 100% of the total cost of the originally scheduled treatment.

I have read the above noted consent and have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed
by my Therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

______________________________ ______________________________

Patient Name Signature of Patient or Guardian

______________________________ ______________________________

Witness Date Signed