Dowswell Chiropractic & Wellness Centre
Stephanie Mueller, RMT
Joanne Kennedy-Dew, RMT
241 West Street, Unit 3
Orillia, Ontario L3V 5C9
Telephone: 705.325.0832 Fax: 705.325.8401

Health History

Client Name: _____ D.O.B.: _____Age: _____
(Day/Month/Year)

Current Address: _____

City: _____ Postal Code: _____ Occupation: _____

Email: _____ Home Phone: _____Cell Phone: _____

Medical Doctor: _____Doctor's Phone Number: _____

Do you have Extended Health Benefits? Yes No Would you like us to set up direct billing? Yes No

Have you received massage therapy before? Yes No

Did a healthcare provider refer you for massage therapy? Yes No

If yes, please provide their name and address: _____

_____

Are you currently receiving treatment from another healthcare professional? Yes No

If yes, for what? _____

Please list ALL major injuries or surgeries, including dates: _____

_____

_____

Treatment you are currently receiving, including medications, what they treat and alternative remedies:

_____

_____

_____

Do you have any internal pins, wires, artificial joints or special equipment? Yes No

If yes, what and where? _____

_____

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What is the reason you are Seeking massage therapy? Please include the location of any tissue or joint discomfort:

_____

Please check ALL conditions you have experienced (Past or Present):

Musculoskeletal and Nervous Systems: Pain / Stiffness / Injury

❏ Neck
❏ Shoulder
❏ Arm / elbow
❏ Upper Back
❏ Mid Back
❏ Low Back
❏ Thigh / Knee
❏ Leg / Ankle

Weakness / Tingling:

❏ Upper Extremity
❏ Lower Extremity
❏ Headaches ❏ Tension
❏ Migraine
❏ Other
- Known Triggers: _____
_____
❏ Whiplash (MVA)
❏ Head Trauma / Concussion
❏ Loss of Co-ordination
❏ Loss of Sensation (Where?)
_____
❏ Dizziness
❏ Sleep or Personality Changes
❏ Fatigue or Light-headedness
❏ Vision Loss: _____
❏ Hearing Loss: _____
❏ Epilepsy / Seizures
❏ TMJ/Tooth/Jaw/Ear Pain
❏ Rheumatoid Arthritis
❏ Osteoarthritis
❏ Family History of Arthritis?
❏ Yes ❏ No
❏ Degenerative / Herniated Disk
❏ Carpal Tunnel Syndrome
❏ Osteoporosis / Bone Disease
❏ Tendonitis / Fibrositis / Bursitis

Circulatory and Breathing Systems:

❏ High Blood Pressure
❏ Low Blood Pressure
❏ Chronic Congestive Heart Failure
❏ Heart Attack / Disease
❏ Chest Pain / Angina / TIA
❏ Stroke / CVA
❏ Phlebitis / Varicose Veins
❏ Pacemaker or Similar Device
❏ Swollen or Cold ❏ Hands
❏ Feet
❏ Diabetes Mellitus
❏ Poor Healing / Bruise Easily
❏ Asthma / Bronchitis / Emphysema
❏ Shortness of Breath
❏ Emphysema
❏ Frequent Colds / Sinus Infections
❏ Chronic Cough
❏ Smoker?

Skin and Immune:

❏ Open Sores / Cuts / Warts
❏ Contagious Skin Disease
❏ Skin Conditions:
_____
❏ Tuberculosis
❏ Hepatitis
❏ HIV
❏ Herpes
❏ Cancer: _____
❏ Allergies / Hypersensitivities:
❏ Latex
❏ Lotion, Gels
Other: _____

Digestive System:

❏ Nausea or Vomiting
❏ Constipation
❏ Diarrhea
❏ *Rapid* Weight Loss
❏ Appetite Changes
❏ Irritable Bowel Syndrome
❏ Ulcers / Hernia
❏ Gull Bladder Problems

Genitourinary Systems:

❏ Hip or Flank Pain
❏ Pregnancy
Due Date: _____
# of Weeks: _____
❏ Number of children: _____
❏ Menopause Symptoms
❏ Painful Urination

Do you …

❏ Exercise: ❏ Regularly
❏ Heavily
❏ Occasionally
❏ Moderate
❏ Light
❏ Main Activity:_____
❏ Sleep Well ❏ Yes ❏ No
❏ Stressed? ❏ Yes ❏ No
❏ *Of course*
❏ Feel Good About Life?
❏ Yes ❏ No

❏ Fractures: _____
_____
❏ Spasm / Sprain / Strain:
_____
_____

The statements made on this form are accurate to the best of my recollection and I agree to an examination for further evaluation.

Client Name (Please Print) _____ D.O.B (Day/Month/Year) _____

Signature _____ Date (Day/Month/Year) _____

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Consent for Massage Therapy

- The information I have provided is true and complete to the best of my knowledge
- I understand the information I have provided on this form is confidential and will not be released without my written consent, except as required or allowed by law
- I will inform the therapist if there are any changes regarding my health status before my next treatment
- I understand that the information provided is necessary for the express and sole purpose of provide a safe and effective treatment
- I understand that the therapist can end treatment at anytime due to inappropriate behaviour
- I consent to a health assessment/reassessment and therapeutic massage treatment
- I understand at least 24 hours' notice is required to reschedule all future appointments
- I consent to receive phone and/or email notifications of my future appointments

Informed Consent for treatment of sensitive areas:

I have requested assessment and/or treatment by the Registered Massage Therapist for the clinically relevant areas indicated below (please initial):

_____ Chest Wall Muscles (not including breasts)

_____ Breast(s)

_____ Buttocks (gluteal muscles)

_____ Upper Inner Thigh(s)

Fee Schedule

30 Minutes	$60
45 Minutes	$75
60 Minutes	$90
90 Minutes	$120

_____ _____
Client Name (Please Print) D.O.B (Day/Month/Year)

_____ _____
Client Signature (Or Legal Guardian) Date (Day/Month/Year)

_____ _____
Witness Name (Please Print) Date (Day/Month/Year)

_____
Witness Signature