Health History Form

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

Name: ______________________ Phone #: ______________

Address: ______________________ Date of Birth (d/m/y): ____/____/____

City: ______________________ Occupation: ______________

Postal Code: __________ Email: ______________________

Have you received massage therapy before? ☐ Yes ☐ No

How did you hear about us? ______________________

Please indicate conditions you are experiencing or have experienced:

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart Attack
- ☐ Phlebitis
- ☐ Stroke / CVA
- ☐ Pacemaker or similar device
- ☐ Heart Disease

Is there a family history of any of the above? ☐ Yes ☐ No

Respiratory

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Is there a family history of any of the above? ☐ Yes ☐ No

Infections

- ☐ Hepatitis
- ☐ Skin Conditions
- ☐ TB
- ☐ HIV
- ☐ Herpes

Other Conditions

- ☐ Loss of sensation, where? ______________
- ☐ Diabetes, onset:
- ☐ Allergies/hypersensitivity to what? ______________
- ☐ Type of reaction: ______________
- ☐ Epilepsy
- ☐ Cancer, where? ______________
- ☐ Arthritis

Is there a family history of arthritis? ☐ Yes ☐ No

Head / Neck

- ☐ History of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Vision loss
- ☐ Ear problems
- ☐ Hearing loss

Women

- ☐ Pregnant, due:
- ☐ Gynaecological conditions, what? ______________

Overall, how is your general health? ______________

Primary Care Physician ______________

Address: ______________

Current Medications: ______________________

Condition it treats: ______________________

Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No

If yes, for what? ______________________

Surgery - Date ______________

Nature: ______________

Injury - Date ______________

Nature: ______________

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness)

☐ Yes ☐ No what? ______________

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

What? ______________

Where? ______________

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

____

Date of Initial Health History: __________
Update 1: __________
Update 2: __________
Update 3: __________
Update 4: __________

Direct Billing Policy

We offer direct billing to select insurance companies for your health care provided at Niagara Falls Massage Therapy & Wellness Centre. This is not a mandatory service but a **courtesy to our clients**. We will try to directly bill only to those companies that may allow for it and for those policies that will pay the health care provider directly. If your insurance company/policy does not pay the provider directly then we will issue you a receipt on payment for you to submit to insurance yourself.

Direct Billing Consent, Authorization and Acknowledgement

Consent to Collect and Exchange Personal Information: I authorize my health care provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer/plan administrator and their service providers for the purposes of assessing my claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud/plan abuse. I confirm I have consent from the primary insured plan member (if not myself) to collect, use and disclose any personal information about them for the same reasons as stated above.

I hereby authorize my health care provider to directly bill my insurance company on my behalf for services provided at Niagara Falls Massage Therapy & Wellness Centre. I acknowledge that if my claim is not paid in part or whole, or is not paid directly to the health care provider, that I will pay any balance owing immediately after treatment. In some cases my credit card information may be saved to my profile (PCI compliant) so that if the health care provider needs to wait on payment details, my credit card can be charged at a later time for any balance owing.

______________________________	______________________________	______________________
Print name	Signature	Date

Privacy Policy

Your health care provider is responsible for all personal information entrusted in writing, as well as all information pertaining to the client. For example, health history and on-going treatment forms. All written and verbal client information is kept private and confidential and cannot be discussed or released unless written consent is given by the client for this release of personal information or as governed by law. Files are stored on location by the owner and can only be accessed by staff.

Cancellation Policy

To better serve our clients, and to avoid a charge, **24 hours' notice is required to change or cancel** existing appointments. If you cancel within 24 hrs or no-show, the following charges will apply:

- 50% of the service fee will be charged for an initial occurrence.
- 100% of the service fee will be charged for any additional occurrence.
- if you have a gift certificate, it will be used as payment.

Without this policy, such activity can negatively affect our availability to our client base. As a courtesy, we will try to email or text message you in advance of your appointment to remind you, if you have provided that contact information. However, we are not responsible if these automated reminders are unsuccessful.

I understand the above Policies and I agree they are fair and reasonable.

Signature:________________________________ Date:_________________________________