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# Muscle Therapy Health Record

On a daily basis we experience physical, chemical and emotional stress that can accumulate and result in serious loss of health potential. Most times the effects are gradual; not even felt until they become serious. Answering the following questions will give us a profile of the specfic stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

**Please be aware that our massage appointments are comprehensive.**
****Change time and consultation time are included within your designated appointment time.****

***RECENT CHANGES TO THE INSURANCE INDUSTRY MAY HAVE AFFECTED YOUR ELIGIBILITY TO BE REIMBURSED FOR MASSAGES. IT IS YOUR RESPONSIBILITY TO KNOW YOUR POLICY. IF YOUR INSURANCE POLICY REQUIRES A THERAPIST WITH A CERTAIN LEVEL OF QUALIFICATION, YOU MUST DISCLOSE THAT INFORMATION AT THE TIME OF BOOKING***

## About You!

Legal Name: _____ Preferred Name: _____

Date of Birth: _____ dd/mm/yyyy Age: _____ ◯ Male ◯ Female

Address: _____

City: _____ Province: _____ Postal Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Occupation: _____

Would you be interested in receiving the following through email:

◯ Newsletters ◯ Appointment Reminders ◯ None

Marital Status: ◯ Married ◯ Common Law ◯ Single ◯ Separated ◯ Divorced ◯ Widowed

Name of Spouse: _____ # of Children: _____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

Alberta Health Care #: _____

Who can we thank for referring you to our office? _____

## Health & History

Medications I now take:

◯ Stimulants
◯ Blood Thinners
◯ Muscle Relaxers
◯ Blood Pressure Medicine
◯ Insulin
◯ Cholesterol Lowering Agents
◯ Pain Killers (including Aspirin)
◯ Other: _____

Have you had: ◯ Xrays ◯ MRI ◯ Ultrasound ◯ CT

When? _____

Where? _____

Please list any surgeries you've had in the past:

_____

Are you pregnant? ◯ Yes ◯ No

How far along? _____ Due date? _____

Any complications with past pregnancies? If yes, please explain: _____

_____

Are you nursing? ◯ Yes ◯ No

## Your Massage Preferences

Have you had massage treatments before? ◯ Yes ◯ No

Is the purpose of this appointment related to: ◯ Job ◯ Sports ◯ Auto Accident ◯ Fall ◯ Other

Preferred type of massage: ◯ Relaxation ◯ Deep Tissue

Areas to focus on: _____

Are you interested in: ◯ Cupping ◯ Hot Stone ◯ Both

**Please be aware that only certain therapists offer these services. Ask the front desk staff for more information.*

What have you tried for relief?

◯ Heat ◯ Cold ◯ Rest ◯ Exercise/Stretching ◯ Physiotherapy ◯ Chiropractic ◯ Massage

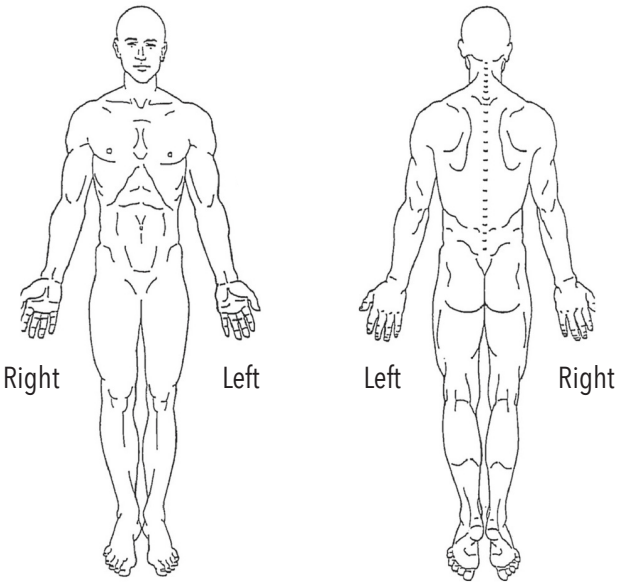
Conversation during treatment? ◯ Yes ◯ No ◯ Sometimes

**Please communicate your pressure and comfort preference with your therapist during treatment, regardless of conversation preferences.*

Are there areas of your body that you prefer <u>not</u> to be massaged? ◯ Feet ◯ Head ◯ Other _____

Use the Key below to indicate the area(s) and type(s) of pain your are experiencing on the body diagrams:

| KEY | |
|---|---|
| / / / / / / Stabbing | 0 0 0 0 Pins & Needles |
| X X X X Burning | = = = = Numbness |




Please indicate (circle) your pain level today on the scale below:

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|

◯ One massage per month (Maintenance)*

◯ Two massages per month*

◯ 1-2 massages per week*

◯ Discuss treatment options with my massage therapist

**The above information should serve as a guideline only. Individual patient circumstances may need to deviate from the above guidelines. If unsure what the right frequency is for your particular case, discuss the options available with your massage therapist.*

## Health Conditions

Please **CHECK** any of the below conditions you are experiencing **currently**, and **UNDERLINE** those you have experienced in the **past**:

**GENERAL**
- ○ Loss of sleep
- ○ Fatigue

**NEUROLOGICAL**
- ○ Fainting
- ○ Seizures
- ○ Numbness in arms / legs / hands / feet

**GASTROINTESTINAL**
- ○ Digestive problems
- ○ Nausea
- ○ Vomiting
- ○ Constipation
- ○ Gallbladder / jaundice
- ○ Colitis / Crohn's / IBS

**MUSCLE & JOINT**
- ○ Spinal curvature (Scoliosis)
- ○ Sciaticia
- ○ Disc problems
- ○ Arthritis (Type: _____)
- ○ Fractures
- ○ Weakness
- ○ Bursitis

**HEAD & NECK**
- ○ Headaches
- ○ Dizziness
- ○ Whiplash
- ○ Vertigo
- ○ Migraines
- ○ Ringing in ears
- ○ Thyroid problems
- ○ Sinus problems
- ○ TMJ disorder

**CARDIOVASCULAR**
- ○ Rapid heart beat
- ○ Slow heart beat
- ○ High / low blood pressure
- ○ Hemophilia
- ○ Blood clots
- ○ Heart murmur
- ○ Congenital heart defect
- ○ Hardening of arteries
- ○ Poor circulation
- ○ Varicose veins / Phlebitis
- ○ Heart surgery / Pacemaker
- ○ Heart attack
- ○ Stroke

**RESPIRATORY**
- ○ Chest pain
- ○ Difficulty breathing
- ○ Asthma

**DIAGNOSED CONDITIONS**
- ○ Shingles
- ○ Rheumatic fever
- ○ Cerebral palsy
- ○ Raynaud's
- ○ Osteopenia
- ○ Osteoporosis
- ○ Cancer / Chemotherapy (Type: _____ )
- ○ Hepatitis
- ○ Venereal disease
- ○ Tuberculosis
- ○ Diabetes (I / II)
- ○ Epilepsy
- ○ Kidney disease
- ○ Parkinson's

**SKIN CONDITIONS**
- ○ Athlete's food
- ○ Warts
- ○ Psoriasis
- ○ Eczema
- ○ Acne

**FOR WOMEN ONLY**
- ○ Cramps or back pain
- ○ Hot flashes
- ○ Menopausal symptoms
- ○ Miscarriage

**ALLERGIES**

Allergies to: _____

_____

Reaction type: _____

_____

Do you carry an EpiPen?

◯ Yes ◯ No

## Massage Therapy Cancellation Policy

Schedule changes must be made **<u>at least 24 hours</u>** in advance to allow for another client to fill the available time. There will be a charge for missed appointments without a phone call. **This is a zero tolerance policy.**

**Fees for missed appointments are as follows:**

- First Time: Warning
- Second Time: 100% of Massage Price

I hereby agree to abide by this policy while under care at The Chiropractic Center for Health. I understand that massage therapy is an aid to health but does not take the place of any care my chiropractor or medical doctor may recommend. I have given correct information regarding my health and am unaware of any reason I should not have massage therapy.

_____ _____

Signature of Patient (or Legal Guardian) Date

# Chiropractic Center for Health
# Dr. Ross Jeske, Dr. John Scott, Dr. Aaron D'Amico and Dr. Shaunessy Keita

## Consent to Massage Therapy Treatment

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your massage therapist and to make an informed decision about proceeding with treatment.

**Benefits**
Massage therapy treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your massage therapist can relieve pain including headaches, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

**Risks**
The risks associated with massage therapy vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms**
  Usually any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn**
  Skin irritation or a burn may occur in association with the use of some types of heat therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain**
  Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the affected area and other minor care.

**Alternatives**
Alternatives to massage therapy may include consulting with other health professionals. Your massage therapist may also prescribe rest without treatment, or exercise with or without treatment.

**Questions or Concerns**
You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the massage therapist's attention. If you are not comfortable, you may stop treatment at any time.

**Please be involved in and responsible for your care. Inform your massage therapist immeditately of any changes in your condition.**

I hereby acknowledge that I have discussed with the massage therapist the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and the risks of treatment, as well as the alternatives to treatment. I hereby consent to massage therapy treatment as proposed to me.

I understand that the massage therapist is providing massage therapy services within the scope of their practice. I understand that the therapist is not a doctor and does not diagnose illness or disease or any other physical or mental disorders. I clearly understand that massage therapy is not a substitute for a chiropractic or medical examination.

I understand that any treatment provided by the massage therapists at this office, when requested without a chiropractic preliminary exam / assessment, is separate and distinct from the practice of chiropractic provided by Dr. John Scott and Dr. Ross Jeske at the Chiropractic Center for Health. I hereby waive any and all liability towards the above mentioned doctors of chiropractic should any injury or malpractice claim result from any treatment, opinion or omission, provided or not provided by the massage therapists at this office.

The information I have provided is true and complete to the best of my knowledge.

_____
Patient Name (please print)

_____ _____
Signature of Patient (or Legal Guardian) Date