Health History Form

Please complete form in full.

Name: ______________________________	Date of birth: ______________________
Address: ______________________________	City: ____________ Postal code: ________
Phone: home: __________________________	Email address: ______________________
cell: __________________________	Occupation: ______________________
work: __________________________	Referred by: ______________________
Emergency contact name and phone #: _______________	How do you hear about us: _______________

An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future please let us know. All information gathered is confidential except as required by law. You will be asked to provide written authorization for release of any information.

☑ **Please indicate conditions you are experiencing or have experienced.**

Cardiovascular
- High blood pressure
- Low blood pressure
- Heart attack
- Heart disease
- Phlebitis
- Varicose veins
- Pacemaker or similar device
- Stroke/CVA Date:____________
- Family History of any

Respiratory
- Chronic cough
- Shortness of breath
- Bronchitis/Pneumonia
- Asthma
- Emphysema
- Smoking
- Family History of any

Head/Neck
- Vision problems
- Vision loss
- Ear problems/Tinnitus
- Hearing loss
- Headaches/Migraine
- Type:________________
- Family History of any

Soft tissue/joint
- Neck
- Low / Mid / Upper back (circle one)
- Shoulders
- Arms R / L
- Legs R / L
- Knees R / L
- Hip
- Elbow
- Other :______________________

Infections
- Hepatitis/liver issues
- TB
- HIV
- Plantar warts
- Other: ______________

Other Conditions
- Loss of sensation
- Diabetes
- Allergies
- Epilepsy
- Cancer
- Arthritis
- Family History of any

Women
- Menstrual problems
- Menopausal
- Children: ___________
- Pregnant
- Due date: ______________
- Breast lumps
- Hysterectomy

Skin
- Skin conditions
- Skin irritations
- Bruise easily
- Rashes

Mental Health
- Depression
- Anxiety
- Other: ________________
- Family History of any

Gastrointestinal
- Irritable Bowel Syndrome
- Chronic Abdominal Pain
- Prolonged Constipation
- Crohn's
- Colitis
- Poor appetite
- Excessive hunger/thirsty
- Belching/gas
- Nausea/vomiting
- Distress from greasy food
- Diarrhea
- Ulcer
- Metallic taste

What is your general health status? ____

Current Medications: ______________________________________ Condition it treats:__________________

Previous Surgery (date & nature): ____

Previous Injury (date & nature): ____________________________________(eg: Dislocation/fracture/car accident)

Other Medical Conditions (e.g. digestive disorders, gynaecological problems): ______________________________

Of Special Note (presence of internal pins, wires, special equipment):______________________________

Primary Care Physician (name & phone number) :______________________________________

Other Healthcare (e.g. chiropractor, naturopath, physiotherapist):______________________________

Do you exercise regularly (i.e. 3 times per week) Yes No If yes, what do you do : ______________________

Jinna's Acupuncture Centre

Patient Informed Consent-REGISTERED MASSAGE ("RMT")

Have you received registered massage therapy before? Yes No If so, date of last visit: ______________________________

What is the reason you are seeking Registered Massage Therapy? ____

Appointment Booking and Policies (*Please read the following requirements carefully):*

	Initial
24 hours notice, during business hours (Monday thru Saturday) is required for cancelling appointments, otherwise you will be charged a non-cancellation fee equivalent to the original appointment fee	
If you miss or do not show up for your appointment you will be charged a non-cancellation fee equivalent to the original appointment fee	
Payment is due upon completion of treatment. Form of Payment accepted is cash, cheque or e-transfer	
I have been made aware of the fee schedule and agree to such rates prior to treatment	
I will advise the clinic prior to treatment whether I require a receipt for registered massage, as registered massage therapy can only be provided by registered massage therapists and must be scheduled as such. I acknowledge that receipts for registered massage therapy will not be issued unless service was provided by a registered massage therapist.	
I have been advised that Tuina massage is a discipline of Traditional Chinese medicine, will **not** qualify for a registered massage receipt and will have a receipt issued as "acupuncture", not "RMT" (registered massage therapy).	

Extended Healthcare Coverage

We do not offer direct billing however we will provide a receipt that can be forwarded to your insurance provider if coverage exists. Please check coverage with your insurance provider in advance of your appointment as to whether you have acupuncture and/or registered massage therapy coverage. If you know what coverage you have for Registered Massage Therapy please note it here for your file.

Annual Limit: $______________

CONSENT TO ASSESSMENTS and TREATMENTS

Registered Massage Therapy involves the manipulation of the soft issues of the body, skin, muscle, ligaments and connective tissues, using techniques to produce therapeutic results.

I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that my therapist has also discussed with me the probability of success of the treatment, as well as risks, and probability of serious side effects. I acknowledge I will discuss with my therapist the nature and purpose of treatment in general and my treatment in particular as well as the content of the Consent. 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 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.

With Registered Massage Therapy, the patient disrobes to their comfort level, and lies on a table between two sheets. Only the areas of the body being directly treated are uncovered at one time. If at any time you are uncomfortable with the pressure or the technique being used, you can tell the therapist (i.e. to decrease or increase pressure, irritating, etc.). You can also stop the treatment at any time.

I have read the above and give consent to treatment from this point forward.

______________________________ ______________________________

Signature Date

Jinna's Acupuncture Centre