Welcome To Scott Family Chiropractic

8 Landsdowne Ave. Woodbridge, ON, L7E 2A9

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 confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Date: _____
(Surname) (First Name)
Address: _____

Home #: _____ Cell #: _____

D.O.B: _____ Occupation: _____

Who referred you for massage therapy? _____
Have you received massage therapy before? __ Yes __ No

Health History: Please indicate conditions you are experiencing or have experienced:

Cardiovascular
__ High blood pressure
__ Low blood pressure
__ CCHF
__ Heart attack
__ Phlebitis
__ Stroke/CVA
__ Pacemaker or similar device
__ Heart disease
__ Varicose veins

Infections
__ Hepatitis
__ TB
__ HIV
__ Herpes

Respiratory
__ Chronic cough
__ Shortness of breath
__ Bronchitis
__ Asthma
__ Emphysema

Head/Neck
__ Headaches
__ Migraines
__ Vision problems/loss
__ Ear problems/loss

(Women Only)
__ Pregnant (*Due*: _____)
__ Gynecological conditions
If so, what? _____

Other Conditions
__ Loss of sensations
If so, where? _____
__ Diabetes (O*nset*: _____)
__ Allergies/hypersensitivity
If so, to what? _____
__ Epilepsy
__ Cancer
If so, where? _____
__ Skin conditions
If so, what? _____
__ Arthritis

Is there a family history of any of the above? __ Yes __ No *If so, which?* _____
What is your primary complaint? _____

Overall, how is your health? _____

Current medications: _____ Condition(s) it treats? _____
Are you currently receiving treatment from another health care professional? __ Yes __ No
If yes, for what? _____
Primary Care Physician: _____ Address: _____
Surgery: _____ Date: _____ Nature: _____

Other Medical Conditions: _____
Do you have any internal pins, wires, artificial joints or special equipment? __ Yes __ No
If yes, what? _____

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.

___ I hereby consent for 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. It is recommended that I attend my personal physician for any ailments that I may be experiencing. 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 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 authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

___ I have read the above noted consent and I 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.

Please read and sign the following:

All appointments for massage are to be booked at the front desk.

All first appointments require a full hour to have a proper assessment.

Cancellations must be made 24 hours in advance. Patients who regularly cancel at the last minute, or miss appointments without canceling in advance, will be charged at regular appointment fee.

NSF Cheques will be charged an additional $20.00 on top of regular fee.

Insurance Coverage, we will be happy to provide you with receipts that you may forward to your insurance company.

Late Arrivals will not exceed the allotted scheduled time and full fee will be charged.

Payment is due at time of service.

I have read the above consent and policies.

___ I have also had an opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions.

Patient signature: _____ Date: _____

Witness Signature (C.H.A.): _____ Date: _____