



**GLEBE**  
chiropractic clinic +  
massage therapy centre

**CONFIDENTIAL CASE HISTORY**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home phone \_\_\_\_\_ Date of birth: dd \_\_\_\_ mm \_\_\_\_ yr \_\_\_\_ email: \_\_\_\_\_

Bus. phone: \_\_\_\_\_ Occupation: \_\_\_\_\_ Chiropractor's name: \_\_\_\_\_

MD name: \_\_\_\_\_ Referred by: \_\_\_\_\_ MD address: \_\_\_\_\_

Are you seeking massage for relaxation?  Yes  No Do you have a specific complaint? Please explain: \_\_\_\_\_

How would you describe your general health status? \_\_\_\_\_

Have you ever seen a massage therapist before?  Yes  No If yes, last visit date? \_\_\_\_\_

**Please indicate conditions you are experiencing, or have experienced:**

Are you interested in strategies to help you continue to feel well or even better?  Yes  No

**Do you now or have you ever had any of the following...**

**Respiratory**

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

**Other Conditions**

- Diabetes (onset: \_\_\_\_\_)
- Allergies (anaphylaxis)
- Skin irritations
- Epilepsy
- Cancer
- Arthritis
- Any family history of Arthritis

**Women**

- Pregnant (due: \_\_\_\_\_)
- Gynecological conditions, describe \_\_\_\_\_.

**Cardiovascular**

- High blood pressure
- Low blood pressure
- Chronic congestive heart failure
- Heart attack
- Phlebitis
- Stroke/CVA
- Pacemaker or similar device
- Heart disease

**Infections**

- Hepatitis
- Skin conditions
- TB
- HIV

**Head/Neck**

- Vision problems
- Vision loss
- Ear problems
- Hearing loss
- Dizziness
- Headaches
- Migraines

Current medication and condition it treats: \_\_\_\_\_

Surgery, dates: \_\_\_\_\_

Injury, dates: \_\_\_\_\_

Present involvement in other Health Care:  Yes  No If yes, please specify: \_\_\_\_\_

Other medical conditions: (eg. depression, digestive, hemophilia, mental illness, osteoporosis, etc.) \_\_\_\_\_

Of special note: (presence of internal pins, wires, artificial joints, special equipment) \_\_\_\_\_

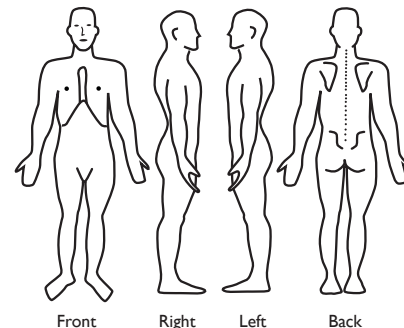
**Are you currently experiencing any of the following....**

Pain:  Yes  No What type? (dull, sharp, shooting...)  
Where? Circle areas on body diagram below

Stiffness:  Yes  No What type? (Muscle, skin, joint...)  
Where? Indicate with an X on diagram below

Numbness:  Yes  No What type? (tingling, lack of sensation...)  
Where? Indicate with // on diagram below

Previous occurrence of above symptoms?  Yes  No



An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let us know.

All information gathered for this treatment is confidential.

You will be asked to provide written authorization for release of any information. Our privacy statement is available upon request. If you have any questions or concerns, please contact our privacy information officer.

#### Fee Schedule

<b>One hour massage</b>	<b>\$95.00 + hst</b>
<b>1 1/2 hour massage</b>	<b>\$142.00 + hst</b>
<b>2 hour massage</b>	<b>\$180.00 + hst</b>

**Payment is due at the time of service and we will provide you with a receipt you can submit to your insurance company for possible reimbursement.**

#### Cancellation Policy

To avoid charges, please provide a minimum of 12 hours notice for cancellation. A 100% cancellation fee will be charged if you cancel your appointment with less than 12 hours notice or if you do not show for your scheduled appointment time.

If your appointment is booked on the same day, please be aware that the cancellation policy will be in effect once your appointment is set. This is done in fairness both to clients who would otherwise have wanted the appointment as well as the therapist, who is not paid if they do not perform the session.

We take pride in the fact that our clients never wait and are never rushed. As a courtesy to everyone, thank you for being prompt. Late arrivals can only be extended to the time remaining in their scheduled session.

I consent to the clinic to communicate electronically with me for the purpose of scheduling appointments, appointment confirmations, clinic updates and newsletters.  Yes  No

\_\_\_\_\_  
Client Signature (or Parent/Guardian)

\_\_\_\_\_  
Dated

The client always has the right to modify, terminate or refuse treatment at any time regardless of prior consent given. If you have any questions about any aspect of massage therapy or specifics of your treatment, feel free to ask your massage therapist.



***Please be a responsible mobile phone user by being considerate to others while in our clinic.***