MASSAGE CLIENT HEALTH HISTORY

First Name:	Last Name:	Gender:
Address:	City/Prov:	Postal Code:
Date of Birth (DD/MM/YY):	Cell Ph:	Home Ph:
Email Address:	How did you hear about us?	

Please indicate conditions you are experiencing or have experienced:

Any cardiovascular or respiratory illnesses? Yes No

If yes:

High or Low Blood Pressure
Congestive heart failure
Heart attack
Varicose veins
Stroke
Pacemaker or similar device
Heart disease Asthma
Bronchitis
Emphysema
Chronic cough
COPD

If not listed, please describe your condition:
____

Any previous head or neck injuries/trauma? Yes No

If yes:

Concussion
Vertigo
Seizures
Vision problems

Spinal surgeries:
If yes, where: ____________________________________

If not listed, please describe your condition:
____

Any previous motor vehicle accidents or other types of accidents? Yes No

If yes, when did it occur? __________________________________
____

Please describe the accident:
____

Any previous surgeries? Yes No If yes, when did you have the surgery? ____ Please describe the surgery: ____
Are you currently pregnant? Yes No If yes, when are you due? ____ Any current complications? ____ **Any previous pregnancies? Yes No** If yes, were there any complications? Please describe: ____________________________________ ______________________________

Additional health questions:

1. Do you have any medical conditions not listed above that we should know about? Yes No

   If yes, please describe: ____

2. Are you currently on any prescribed medications? Yes No

   If yes, please list them: ____

24-Hour Notice for Cancellation of Massage Appointments:

I understand that I will incur and be responsible for a fee of **50% of the massage price** for same-day cancellations or missed appointments.

Initial here: ________________

Acknowledgement:

I acknowledge that the Massage Therapist is not a physician and does not diagnose illnesses, diseases, or any other physical or mental disorders. 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 assurances or guarantees have been provided to me as to the results of the treatment. I acknowledge and understand that the Massage Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Massage Therapist and disclosed all 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.

____________________ **Signature**	____________________ **Date**	____________________ **Therapist Signature**

CONSENT TO DIRECT BILL

Name of Insured Member: ____________________________ DOB of Insured Member: __________________________

Insurance Provider: ______________________________

Policy/Plan Contract #: ______________________ Member/Group ID #: ______________________________

I, ________________________________, authorize Willow Park Village Chiropractic and Natural Health to collect, use, and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the purposes of:

- § Assessing and submitting claims
- § Auditing and administering the group benefits plan, including the investigation of fraud and/or plan abuse

I agree that a photocopy or electronic version of this authorization shall be valid as the original and may remain in effect for the continued administration of the group benefits plan.

____
Date

______________________________ ______________________________
Name of Insured Plan Member (Print) Signature of Insured Plan Member

______________________________ ______________________________
Name of Witness Signature of Witness