thrive
NATURAL FAMILY HEALTH

Date of initial health history: ____________
Update 1: ____________
Update 2: ____________
Update 3: ____________
Update 4: ____________

## Confidential Health History Form

The information request below will assist us in treating you safely. Feel free to ask questions about the information being requested. Please note that all information will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

*Name:* ____________ *Date:* ____________

*Address:* ____________ *Date of Birth:* ____________

*City:* ____________ *Postal Code:* ____________ *Work No:* ____________

*Occupation:* ____________ *Cell No:* ____________

*Email Address:* ____________ *Family Physician:* ____________

*Emergency Contact:* ____________ *Physician Phone Number:* ____________

### General Questions

*Have you had therapeutic massage before?* ☐ *Yes* ☐ *No* *If yes, how often?* ____________

*What are your goals for your massage today?* ____________

### Health Information

*Are you currently under the care of a physician?* ☐ *Yes* ☐ *No* *If yes, please indicate the condition for which you are being treated:* ____________

*Are you taking any medications?* ☐ *Yes* ☐ *No* *If yes, please list current medications:* ____________

*Have you had any surgeries?* ☐ *Yes* ☐ *No* *If yes, please describe:* ____________

*Have you had any injuries or accidents?* ☐ *Yes* ☐ *No* *If yes, please describe:* ____________

*Do you have any pins, wires, artificial joints or special equipment?* ____________

*Are you pregnant or trying to become pregnant?* ☐ *Yes* ☐ *No*

*If you are pregnant, how many weeks are you?* ____________

*Are there any associated conditions with your pregnancy?* ____________

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

**Head/Neck**

☐ *History of headaches*

☐ *History of migraines*

☐ *Vision problems*

☐ *Vision loss*

☐ *Hearing problems*

☐ *Hearing loss*

**Respiratory**

☐ *Chronic cough*

☐ *Shortness of breath*

☐ *Bronchitis*

☐ *Asthma*

☐ *Emphysema*

☐ *Smoker, how much?* ____________________

**Cardiovascular**

☐ *High blood pressure*

☐ *Low blood pressure*

☐ *Congestive heart failure*

☐ *Heart attack*

☐ *Phlebitis/Varicose veins*

☐ *Stroke*

☐ *Pace maker/similar device*

☐ *Heart disease*

*Is there family history of any of the above?*

______________________________

**Other conditions**

☐ *Numbness or tingling? Where?* ____________________

☐ *Diabetes, type/onset?* ____________________

☐ *Allergies/hypersensitivity, to what?* ____________________

☐ *Cancer/tumours, where?* ____________________

☐ *Skin conditions, what?* ____________________

☐ *Arthritis* ☐ *Osteoporosis* ☐ *Fibromyalgia*

**Infection**

☐ *Hepatitis* ☐ *Skin conditions* ☐ *TB* ☐ *HIV*

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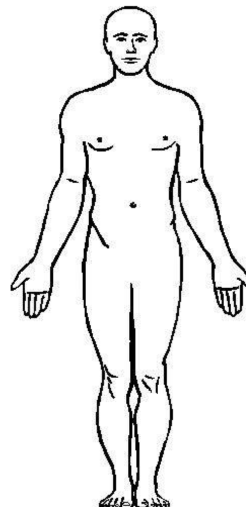
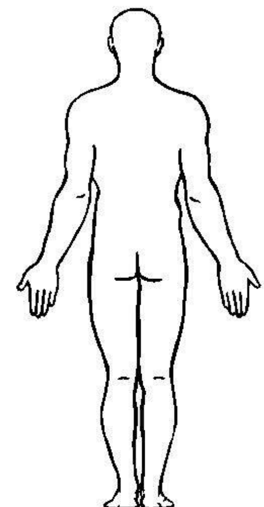
*On a scale of 0 (no stress) to 10 (high levels of stress),*
*please indicate the general amount of stress in your life: 0* ____________________ *10*

*On the figures to the right, please indicate the following areas:*

1. *Where you carry tension (T)*
2. *Areas of discomfort or pain (D)*
3. *Where you hold your stress (S)*





# Consent Information

We would like your consent. We want you to understand the services we hope to provide to you, the cost involved, and what we do with personal information we obtain from you. If you have any questions regarding the following information, please do not hesitate to ask.

**Consent for Treatment**

I have read and understand all of the associated forms, answered them truthfully and to the best of my knowledge, and fully consent to treatment at Thrive Natural Family Health. I also understand that the healthcare practitioners employed at the clinic are independent contractors and I will address any concerns about my treatment directly with my therapist.

**Consent for Cost of Our Service**

I understand that I am being charged by Thrive Natural Family Health for time with a therapist, which may include, but is not limited to: assessment, treatment, lifestyle counselling and home care prescription.

**Consent for Personal Information**

I understand that in order to provide me with the services I am seeking, Thrive Natural Family Health will collect some personal information about me (ie. home phone number, address and emergency contacts).

Thrive keeps all your personal information private and do not give away your email address ever. Once a month we send out a newsletter that has informative articles and updates on workshops or clinic events. Check the box below if you would like to receive emails from Thrive.

☐ **I would like to receive your monthly newsletter and clinic event updates.**

Name ________________________ Signature ______________________

Witness Name: ________________ Witness Signature: ______________________

# Cancellation Policy

I understand that sometimes things come up and you have to cancel at the last moment. Life happens. For all other times, as a courtesy to other clients, and to me, I ask that you notify me a minimum of 24 hours in advance if you must reschedule or cancel your appointment. You will receive an email from our online booking system the day before your appointment as a reminder as well. There will be a 50% charge to your account that can be payed on your next visit.

☐ I have read and understand the cancellation policy.