Westmount Chiropractic Office
Ross Banerjee, RMT
Health History Form (2 pages)

Massage Therapy is the manipulation of the soft tissues of the body, in order to gain a therapeutic response. Soft tissues include muscles, skin, and connective tissues (fascia, tendons, and ligaments). On the table and/or chair, Ross will perform a variety of techniques, such as Swedish massage, Trigger Point Therapy, Myofascial Release, Positional Release, K-Taping, Temporomandibular Joint Treatment, Relaxation, hydrotherapy, remedial exercises, stretches, and postural recommendations.

Because you are spending your time and money to receive therapy, ***you are the boss***. At any time during the course of your massage, you have the right to ask any questions, modify, or terminate the treatment to be comfortable.

During the first visit, you will be asked for a ***confidential*** medical history, which will help Ross form an assessment of your condition and treatment plan. The massage will take place in an atmosphere of **safety** and **confidentiality**, therefore you will not be asked to disrobe beyond your comfort level, you will not be expected to put up with more pain than you wish to tolerate, and you will be treated with respect and dignity. Massage therapy is a partnership between you and your therapist, but your therapist (Ross in this case) cannot do all the work by himself. You live in your body 24 hours a day and 7 days a week, so you are responsible for the times between your treatments. If you do the suggested remedial exercises, stretches, heat or cold applications, your treatment may be even more effective.

Payment — cash *or* ***cheque*** *made out to* Ross Banerjee *or* ***debit card*** *or* ***credit card*** (at the office)
cash *or* ***cheque*** *made out to Ross Banerjee* (during home / office visits)
15 min — $35 ::: 30 min — $50 ::: 45 min — $65 ::: 60 min — $80 ::: 75 min — $95 ::: 90 min — $110

Name: _____ Email: _____
Address: _____
Phone #s: (h) _____ (w) _____ (c) _____
Occupation: _____ Date of Birth: _____
MD Name: _____ MD Phone: _____

What is your main complaint? _____ ❑ Stress ❑ Injury ❑ Stress ❑ Other

Are you seeing any other health care therapist? ❑ Chiropractor ❑ Homeopath ❑ Acupuncture ❑ Physiotherapist ❑ Other _____
How effective has the therapy been? ❑ Very Effective ❑ Somewhat Effective ❑ Not Effective

Do you exercise? ❑ Daily ❑ 5-6 days per week ❑ 3-4 days per week ❑ 1-2 days per week ❑ Rarely
What exercises do you do? _____

Of the following conditions, please ☑ Check, Underline, and / or *specify* which of the following are giving you discomfort:

Musculoskeletal pain
❑ Head _____
❑ Face _____
❑ Jaw _____
❑ Neck _____
❑ Shoulder _____
❑ Arm _____
❑ Hand _____
❑ Upper back _____
❑ Lower back _____
❑ Hip _____
❑ Thigh _____
❑ Hamstring _____
❑ Knee _____
❑ Calf _____
❑ Shin _____
❑ Ankle _____
❑ Foot _____
❑ Medications _____

Circulation
❑ High BP _____
❑ Low BP _____
❑ Heart Condition _____
❑ Diabetes _____
❑ Varicose veins _____
❑ Poor Circulation _____
❑ Bruise easily _____
❑ Poor healing _____

Nerves
❑ Numb / Tingle _____
❑ Shooting pain _____
❑ Muscle weakness _____
❑ Epilepsy _____

Skin
❑ Sensitive Skin _____
❑ Open Sores _____
❑ Contagious Conditions _____

Digestive
❑ Nausea _____
❑ Constipation _____
❑ Kidney/Bladder _____
❑ Poor Digestion _____

Immune
❑ Allergies _____
❑ HIV _____
❑ Cancer _____
❑ Asthma _____
❑ Smoking (packs / day) _____

Women only
❑ Pregnant (weeks) _____
❑ Painful periods _____
❑ Children _____

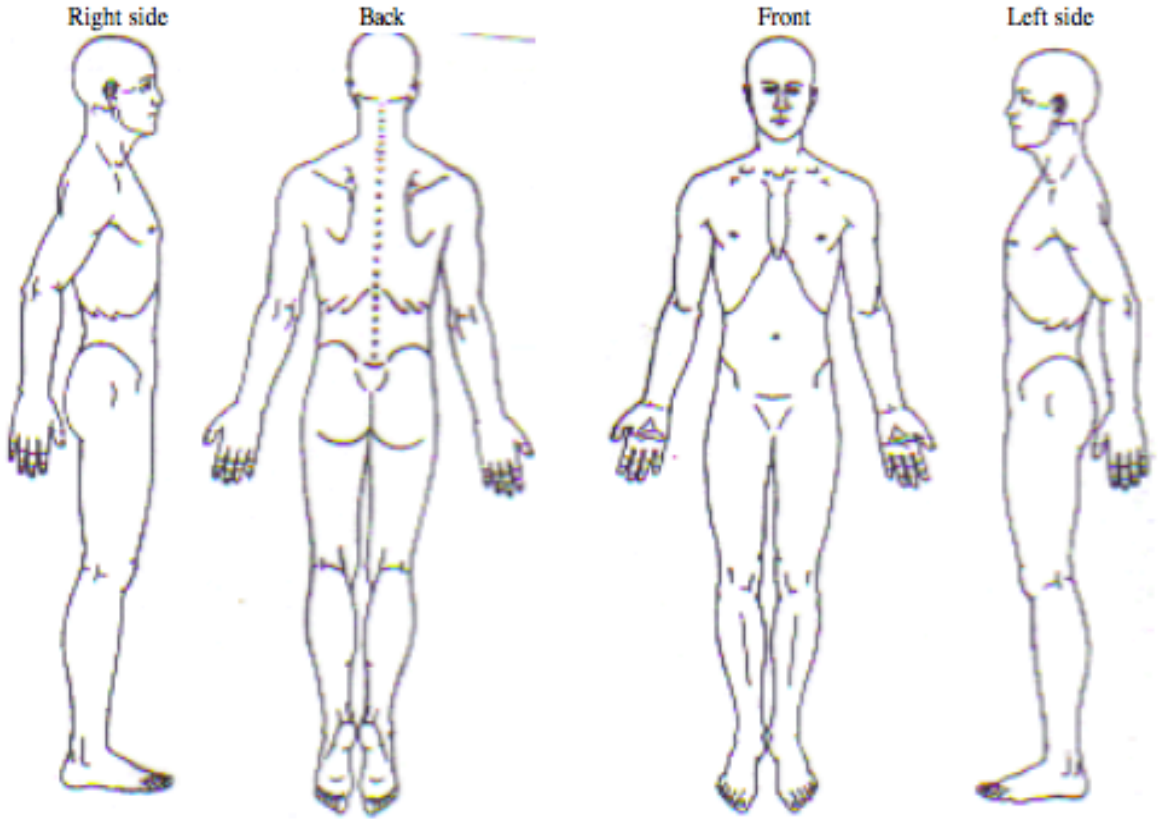
Handedness (dominance)
❑ Left ❑ Right

Other
❑ Corrective Eyewear
❑ Infectious Disease *List Below*
❑ Surgery *Type / Date*

Any concerns not mentioned:

continued overleaf.

On the following bodies, please mark where you are experiencing the greatest discomfort:



PLEASE NOTE:

Scented products release chemicals which can trigger serious health reactions in people with asthma, migraines, allergies or chemical sensitivities.
Please avoid the use of perfume, cologne, scented hairspray, and other scented products.

PATIENT DECLARATION

My therapist has the right to refuse to treat, if there is reasonable cause.

I certify that all the above information is true, and that I will notify my therapist of any changes.

I have read and fully understood all information included in this consent document.

Anything that was unclear was discussed and explained by my therapist. I confirm that I am capable of consenting to treatment; I acknowledge that consent is voluntary and I understand that I may withdraw my consent at any time. I hereby consent to participate in this therapeutic relationship.

Signed _____ Date _____