CLOVER THERAPEUTIC
WELLNESS CENTRE

Health History Form

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

Name: _____ Phone #: _____

Address: _____ Date of Birth (d/m/y): ___/___/___

City: _____ Occupation: _____

Postal Code: _____ Email: _____

Have you received massage therapy before? ☐ Yes ☐ No

How did you hear about us? _____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart Attack
- ☐ Phlebitis
- ☐ Stroke / CVA
- ☐ Pacemaker or similar device
- ☐ Heart Disease

Is there a family history of any of the above? ☐ Yes ☐ No

Respiratory

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

Is there a family history of any of the above? ☐ Yes ☐ No

Infections

- ☐ Hepatitis
- ☐ Skin Conditions
- ☐ TB
- ☐ HIV
- ☐ Herpes

Other Conditions

- ☐ Loss of sensation, where? _____
- ☐ Diabetes, onset: _____
- ☐ Allergies/hypersensitivity to what? _____
- ☐ Type of reaction: _____
- ☐ Epilepsy
- ☐ Cancer, where? _____
- ☐ Arthritis

Is there a family history of arthritis? ☐ Yes ☐ No

Head / Neck

- ☐ History of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Vision loss
- ☐ Ear problems
- ☐ Hearing loss

Women

- ☐ Pregnant, due: _____
- ☐ Gynaecological conditions, what? _____

Overall, how is your general health? _____

Primary Care Physician _____

Address: _____

Current Medications: _____

Condition it treats: _____

Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No

If yes, for what? _____

Surgery - Date _____

Nature: _____

Injury - Date _____

Nature: _____

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness)

☐ Yes ☐ No what? _____

Do you have any internal pins, wires, artificial joints or special equipment? ☐ Yes ☐ No

What? _____

Where? _____

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort:

_____

3710 Main Street Unit 101
Niagara Falls, ON L2G 6B1
289-296-4610

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Direct Billing Policy, Consent, Authorization

Clover Therapeutic Wellness Centre offers direct billing to a number of insurance companies for services provided for your healthcare. This service is a courtesy to our clients. We will try to direct bill to insurance companies and polices that allow for it and that will pay the healthcare provider directly. If your insurance company or policy does not allow for direct billing we will provide you a receipt for the service you have received and paid for and you will be able to submit it on your own for reimbursement.

I _____ authorize my health care provider to collect, use and disclose personal information concerning any claims on my behalf with the insurer, plan administrator and their service providers for the purpose of assessing my claims, underwriting, investigating, auditing and administering the group benefit plan, including the investigation of fraud or plan abuse. I confirm I have consent from the primary plan/policy member (other than yourself) to collect, disclose and use any personal information about them for the purposes stated above.

I _____ authorize my health care provider to directly bill my insurance company on my behalf for the services provided to me at Clover Therapeutic Wellness Centre. I am aware that if my claim is not paid in part or full and or is not paid directly to the service provider, that I will **pay any balance owing immediately after the treatment. In some cases my credit card information may be requested and saved to my profile and charged if the treatment claim submitted is not paid or there is a balance remaining.**

_____	_____	_____
Print Name	Signature	Date

Privacy & Cancellation Policy

Your health care provider is responsible for all personal information interested in writing, as well as all information pertaining to the client. For example, health history and ongoing treatment forms. All written and verbal client information is kept private and confidential and cannot be discussed or released unless written consent is given by the client for this release of personal information or as governed by law. Files are stored on location by the owner and can only be assessed by staff.

To better serve our clients **we require at least 24 hours notice for changes or cancellations to your appointment.** If you cancel within 24 hours of your appointment or you miss the appointment altogether you may be asked to pay the amount of the session you missed or if you have a gift certificate it will be used as a payment towards that service.

I acknowledge the above policies to be reasonable

Signature: _____

Date: _____