healthworks
chiropractic & wellness centre

Hydro Therapy Stimulation

Date: ______________________

Please Read Carefully

An accurate health history is important to ensure that it is safe for you to receive hydro therapy. If your health status changes in the future, please let Health Works Chiropractic & Wellness Centres' practitioner know. Health history will be updated yearly. All information gathered for this treatment is confidential except as required or allowed by law; or except to facilitate assessment or treatment. You will be asked to provide written authorization for release of any information.

Name: ______________________________________

City: ______________________________________

Home Phone Number: _(_____)______________________

Cell Phone Number:_(_____)______________________

Cell Phone Company Name: ______________________

Work Phone Number: _(_____)__________________

Emergency Contact: ______________________

Emergency Phone Number: _(_____)____________

Address: ______________________________________

Province: ________________ Postal Code: ____________

Occupation:______________________________________

Birth Date: ______/_______/______ Age: ________
MM / DD / YEAR

How would you like appointment reminders? ☐Text ☐Email

Email Address:______________________________________

Referred by:

____

Client Information Sheet for the Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an important part of providing you with quality hydro therapy. This information sheet will provide you with a general outline to ensure that:

- Only necessary information is collected about you. Your information is only shared with your consent.
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols.
- Health Works Chiropractic & Wellness Centres' privacy protocols comply with privacy legislation, standards of our regulatory body, the College of Chiropractic Doctors of Ontario and the Law.
- Your files and their contents are the property of Health Works Chiropractic & Wellness Centre and shall be used by our designated Hydro Therapy Practitioner.

I understand and/or agree to the following:

- I have the right to discontinue my assessment of hydro therapy treatment at any time.
- I have fully disclosed all medical conditions that I am aware of and understand that it will be my responsibility to inform a practitioner of any changes in my health status.
- I intend this consent to apply to all of my present and future hydro therapy care, provided through Health Works Chiropractic & Wellness Centre.

As stated in the "Consent to Treatment" Act, I have the right to consent to all or part of the session, or to withdraw consent at any time and have the right to know specifically what I am consenting to. I have the right to ask questions at any time and to communicate information (such as pain/discomfort levels) throughout the session to ensure my own safety and the effectiveness of the session.

I confirm that the information on this form is complete and true to the best of my knowledge and I understand that it is my responsibility to inform my practitioner of any changes in my health status, as they occur.

____________	____________	____________
Date	**Print Name**	**Client Signature**
Date	**Print Name**	**Witness' Signature**

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Hydro Therapy

Treatment Notes for: ____________________ Date: ____________________ DOB: ____________________

Please fill in the form as completely as possible. Accuracy is very important.

Health History **Please indicate any conditions you are experiencing or have experienced.**

Cardiovascular
- ☐ congestive heart failure
- ☐ low blood pressure
- ☐ high blood pressure
- ☐ pacemaker / device
- ☐ heart disease / heart attack
- ☐ stroke / CVA
- ☐ other: ____________________

Respiratory
- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ emphysema
- ☐ asthma
- ☐ other: ____________________

Infections
- ☐ hepatitis
- ☐ skin infection: ____________________
- ☐ TB
- ☐ HIV
- ☐ other: ____________________

Bone
- ☐ arthritis/family history
- ☐ osteomalacia
- ☐ osteoporosis
- ☐ acute inflammation
- ☐ swollen joints
- ☐ other

Other Conditions
- ☐ diabetes, onset: ____________________
- ☐ varicose veins
- ☐ skin irritations or conditions: ____________________
- ☐ loss of sensation, where? ____________________
- ☐ phlebitis
- ☐ cold hands and / or feet
- ☐ epilepsy
- ☐ allergies: ____________________
- ☐ cancer
- ☐ other: ____________________

Women
- ☐ pregnant women
  due date: ____________________

Soft Tissue / Joint Discomfort
(please state nature of concern)
- ☐ Radiating pain: ☐ back ☐ upper body ☐ lower body
- ☐ neck: ____________________
- ☐ shoulders: ____________________
- ☐ upper back: ____________________
- ☐ mid back: ____________________
- ☐ low back: ____________________
- ☐ arms: ____________________
- ☐ legs: ____________________
- ☐ other: ____________________

Head / Neck
- ☐ vision problems
- ☐ do you have hearing aids?
- ☐ vibration sensitive? ie. tens unit
- ☐ hearing problems / loss
- ☐ sinus problems
- ☐ TMJ (jaw problems)
- ☐ headaches / migraines
- ☐ other: ____________________

Did a health care practitioner refer you for hydro massage therapy? ☐ Yes ☐ No

Who may we thank for referring you to this office? ____________________

Other medical conditions: ____________________

Injury or Surgery: ____________________ Date: ____________________

____________________ Date: ____________________

Medication:

____________________ Taken For: ____________________

____________________ Taken For: ____________________

Practitioner's Comments:

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