Power Health Chinook
Chiropractic, Acupuncture and Massage Therapy

PATIENT INFORMATION

Name: _____ Date: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

❍ Single ❍ Married ❍ Widowed ❍ Separated ❍ Divorced Number of Children: _____

Date of Birth (MM/DD/YYYY) _____ Age: _____ Gender: ❍ Male ❍ Female

Alberta Health Care Number: _____

Phone Numbers: Home: _____

Business: _____

Cell: _____

Email Address: _____

Would you like email reminders for appointments? ❍ Yes ❍ No

Would you like to receive our Monthly Health Tips by email? ❍ Yes ❍ No

Spouse/ Partner: _____

In case of emergency, whom should we notify? _____

Relation to you: _____ Contact number: _____

Your Occupation: _____ Employer: _____

Have you had previous Chiropractic care/Physiotherapy/Acupuncture? Yes No

Reason: _____ Date: _____

REFERRAL INFORMATION

How were you referred to us?

❍ Personal Referral: _____ ❍ Internet

❍ Physiotherapist ❍ Location

❍ Massage Therapist ❍ Family Physician: _____

❍ Other: _____

If you weren't referred, how did you hear about us? _____

GENERAL & MEDICAL INFORMATION

What brings you in for a massage? (Stress/pain relief/tension/other reason) _____

_____

_____

Your last massage was? _____

Is your condition related to a car accident? ❍ Yes ❍ No

Are you currently having any discomfort and pain? ❍ Yes ❍ No

If yes, where? (Please indicate area on diagram #1 below) :

Diagram #1 - For Client Use Only

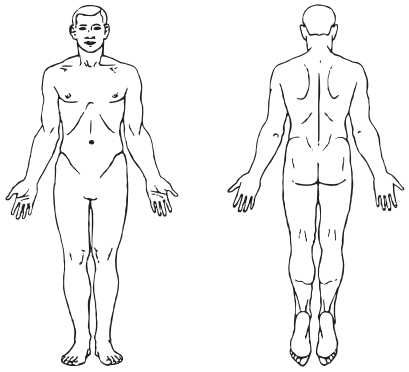
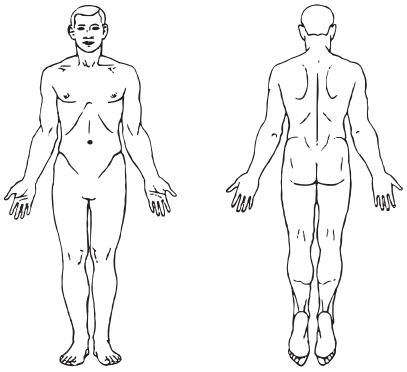


Diagram #2 - For Therapists Use Only



Do you know the cause of the pain? (Disease, specific movement, specific task, weather, etc.?) _____

_____

How long have you had the pain? _____ When do you experience the pain? _____

How would you describe the pain? (Sharp, dull, numbness, etc.) _____

_____

Is there something that aggravates the pain? _____

Have you seen your family doctor lately for this particular problem, or other problem and has she/he recommended any treatment? _____

Have you ever had any surgery? If yes, when? _____

_____

_____

_____

Please describe any significant injuries, traumas or accidents. (Include year & treatment) _____

_____

Do you presently suffer from the following? (Please check all applicable)

❍ Infectious Disease	❍ Headaches	❍ Joint Pain (arthritis)	❍ AIDS
❍ Allergies	❍ High Blood Pressure	❍ Low Blood Pressure	❍ Tingling/Numbness
❍ Cancer	❍ Jaw Pain	❍ Flu	❍ Cold
❍ Painful Calves	❍ Varicose Veins	❍ HIV Positive	❍ Muscle Cramps
❍ Hepatitis	❍ Skin (psoriasis, shingles or other)		

Do you suffer from any other condition that is not mentioned above?_____ If yes, please describe: _____

_____

Are you currently taking any medication?_____If yes, please list:_____

INFORMED CONSENT

Name of Client: _____

I understand that the massage I receive is provided for the basic purpose of relaxation, stress reduction and relief of muscular tension. I further understand that massage should not be constructed as a substitute for medication, examination, diagnosis or treatment and that I should see a physician, Chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of.

I understand that massage therapists are not qualified to perform skeletal adjustments, diagnose and or prescribe, and that nothing said in the course of the session should be constructed as such.

Because massage is contraindicated under certain conditions, I affirm that I have stated all my known medical conditions, and answered all the questions honestly. I agree to keep the therapist updated as to any changes in my medical profile, and understand that there shall be no liability on the therapists part should I forget to do so.

It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in the immediate termination of the session and I will be liable for payment for the full scheduled appointment.

Any massage appointments that have not been cancelled within 24 hours notice or that have been missed will be charged to the patient at 50% of the going rate.

Signed: _____ Date: _____

Therapist: _____ Date: _____