Merivale Chiropractic Clinic
460 West Hunt Club Road
Ottawa, ON K2E 0B8
613-226-8142

FOR OFFICE USE Date: _____ ID#: _____

Massage Therapy (Patient Introduction)

Personal History

☐Mr., ☐Mrs., ☐Miss, ☐Ms., ☐Dr., ☐Mstr.

First Name: _____ Surname: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Email: _____

☐ Check this box if we may contact you via email with our monthly newsletter, promotions, contests, and prizes.

Business Employer: _____ Type of Work: _____

Birthdate: (DD-MM-YYYY) _____-_____-_____ Sex: ☐M ☐F

Height: _____ Weight: _____

Who is Responsible for Your Bill? ☐You ☐Spouse ☐Auto Ins ☐Extended Health Ins

How did you hear about our clinic? _____

Current Health Condition

Major Complaint: _____

General Health Condition ☐Terrible ☐ Poor ☐ Okay ☐ Fine ☐ Good ☐ Great

Previous Treatment for this Condition: _____

When did this condition begin? _____ Other family with same condition? _____

If disabled from work please give dates: _____

Are you currently involved with another Health Care Practitioner? _____

Health History

Medical Doctor* Name _____ Phone # _____ ☐ N/A

***(Information required)** Address _____

Medication You Now Take: ☐Nerve Pills ☐Insulin ☐Blood Pressure ☐Pain Killers ☐Muscle Relaxants

☐Other _____

Major Surgery/Operations: ☐Appendix _____ ☐Tonsils _____ ☐Hernia _____

(Please give date) ☐Heart _____ ☐Back _____ ☐ Neck _____

☐Leg _____ ☐other _____

Major Accidents or Falls: _____

Hospitalization (other than above): _____

Family History of Arthritis: ☐Yes ☐No

Have you had Massage Therapy before? ☐Yes ☐No

Have you been treated for any health conditions in the last year? ☐Yes ☐No

If yes, explain: _____

Health History (cont'd)

MUSCLE OR JOINT PAIN

- ☐ Neck
- ☐ Low back
- ☐ Mid back
- ☐ Upper back
- ☐ Shoulders
- ☐ Leg: left/right
- ☐ Knee: left/right
- ☐ other: _____

HEAD/NECK

- ☐ Headaches
  How often? _____
- ☐ Migraines
  How often? _____
- ☐ Vision problems
- ☐ Contact lenses
- ☐ Glasses
- ☐ Earaches

CARDIOVASCULAR

- ☐ High BP
- ☐ Low BP
- ☐ Poor circulation
- ☐ Heart disease
- ☐ shortness of breath
- ☐ Phlebitis
- ☐ Varicose veins
- ☐ Stroke / CVA
- ☐ Pacemaker or Similar device

RESPIRATORY

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Smoke _____
  (How many? How long?)
- ☐ Breathing problems
  Type: _____
- ☐ Emphysema

EXERCISE/SPORTS

- ☐ Regular exercise

Type of activity _____
Times per week _____
Specific training _____
(What event? When?)

- ☐ Chronic pain/injury
  associated with activity
- ☐ Acute pain/injury
  associated with activity

DIGESTIVE/URO-GENITAL

- ☐ Difficult digestion
- ☐ Constipation
- ☐ Liver/Gall bladder

OTHER CONDITIONS

- ☐ Sinus
- ☐ Allergies
  Type: _____
- ☐ Colds
  Frequency: _____
- ☐ Insomnia
  Hours of Sleep: _____
- ☐ Cancer

Type: _____

- ☐ Arthritis

Type: _____

- ☐ Epilepsy
- ☐ Loss of Sensation
  Where: _____
- ☐ Diabetes

SKIN/INFECTION

- ☐ Skin conditions

Type: _____

- ☐ Bruise easily
- ☐ Hepatitis
- ☐ TB
- ☐ HIV
- ☐ Herpes

WOMEN ONLY

- ☐ Menstrual problems
- ☐ Painful
- ☐ Heavy
- ☐ Scant
- ☐ Pregnant?

Due date: _____

- ☐ Other Form Filled

ADDITIONAL INFO

☐ Presence of internal pins, wires, artificial joints, etc

_____

_____

I understand that the information that I give on this form will be confidential and will be used for no other purpose than the professional clinical records of this office. I understand that I am required to give **24 HOURS NOTICE** of appointment cancellation or I will be charged the full fee for a missed appointment.

_____
Signature of Client

_____ Date: _____
Therapist

Date of Initial Health History
Update 1
Update 2
Update 3
Update 4

Patient Accepted: ☐YES ☐NO INIT _____