THE MASSAGE CLINIC
HEALTH CENTRES

Chiropractic - Intake Form

Contact Information

Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. ☐ Sir

Name: ____ Address: ____

City: ___________________________________ Province: _________________ Postal Code:__________________________

Phone #: Home: _________________________Work: ___________________ Cell: _________________________________

Email: ____ Date of Birth: Day_____Month_____Year______

Gender: ☐ Male ☐ Female

Occupation: ________________________________ Hrs/week: __________ Work posture: __________________________

Emergency Contact Name: ____ Phone #: _______________________________

Emergency Contacts Relationship to You: ____

Medical Information

Family Physician: ____ Phone: (____)______________________

Address: ______________________________ City: ______________ Province: ________ Postal Code:_________________

Previous Treatment:

☐ Athletic Therapist ☐ Chiropractor ☐ Massage Therapist ☐ Acupuncturist ☐ Other ___________________________

Name (or Clinic Name):____ Date of Last Visit: __________________

How did you hear about us?

☐ Bell Yellow Pages ☐ Other Yellow Pages ☐ Internet
☐ Yellowpages.ca ☐ White Pages ☐ Website
☐ Referral:______________ ☐ Walk In ☐ Other: ____________
☐ Advertisement (Location):______________

Chief Complaint

Reason for this appointment? (Chief Complaint) ____

When did your condition begin? ____

Is this condition related to: ☐ Occupation ☐ Car Accident ☐ Fall ☐ Sports Injury ☐ Other

Has this condition occurred before: ☐ Yes ☐ No

Are you currently taking any medication for this condition?: ☐ Yes ☐ No

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Have you seen a health care professional for this condition?: ☐ Yes ☐ No

If yes, who?:

____

_

When is your pain the worst? ☐ Morning ☐ Mid-day ☐ Evening ☐ All day

What aggravates your pain? ____

What relieves your pain? ____

Does the pain affect your work, family life or recreational activities? ☐ Yes ☐ No

Does this condition cause you anxiety, stress, and / or depression? ☐ Yes ☐ No

Have you had any advanced tests performed for this condition? (X-Rays, CT, MRI,

Nerve Conduction Study, Ultrasound etc...)

☐ Yes ☐ No If yes: Date: ________________ Testing type: _____________

Symptom Diagram

On the diagrams below, please outline the area(s) of discomfort. Please use symbols provided that best

represent the pain or sensation(s) you are experiencing.

Symbols:

Numbness : ===============

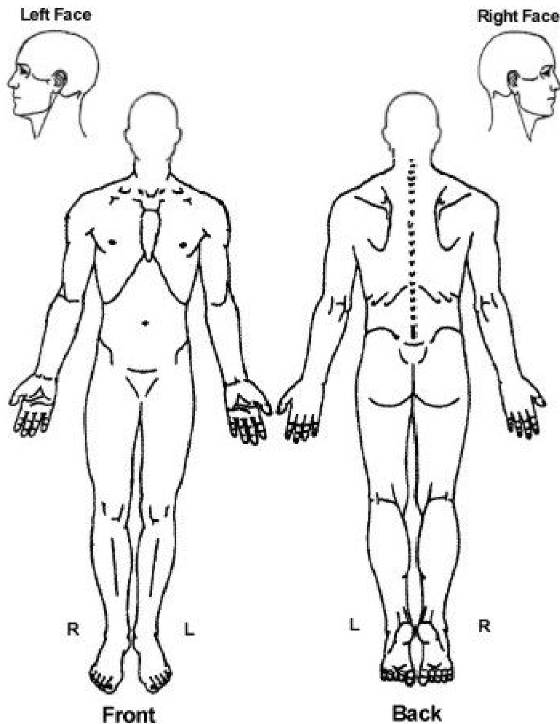
Pins & Needles : ::::::::::::::::

Burning : xxxxxxxxxxxx

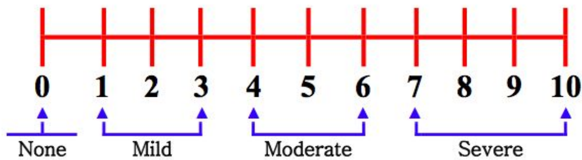
Stabbing & Sharp : oooooooooooooo

Dull & Aching : +++++++++

Stiff & Tight : 22222222



Please indicate your level of pain along the line below with an “x”. 0 represents no pain and 10 represents the worst pain you have ever felt.



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Lifestyle

Please check all that apply:

☐ alcohol No. of drinks (e.g. wine, spirits, beer) per week: _____________

☐ caffeine No. of drinks (e.g. coffee, tea) per day: _____________

☐ smoking No. of cigarettes per day: _____________

☐ exercise No. of hours per week: ________ Type(s) of Exercise: ____________________

List all allergies, if any: (food, environmental, etc.): ____

Medical History

Previous hospitalizations: ____

Have you had any surgeries?: ____

History of major injuries:(MVA, dislocation, sprain, fracture, etc.) _________________________________

Do you have all of your standard vaccinations? ☐ Yes ☐ No

For Women: No. of Pregnancies:_______ No. of children: ________ Are you pregnant: ☐ Yes ☐ No

Are you currently taking any medications on a regular basis?

Please indicate medication name and dosage;____

Do you have or have you ever had any of the following?

☐ Cancer
☐ Anemia
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ Stroke
☐ Heart Disease
☐ Pleurisy
☐ Arthritis
☐ Rheumatoid Arthritis

☐ Influenza
☐ Psoriasis
☐ Tuberculosis
☐ Eczema
☐ Rheumatic Fever
☐ Gall stones
☐ Kidney stones
☐ Sensitive skin
☐ Problem acne
☐ Dermatitis

☐ Venereal disease
☐ Measles
☐ Polio
☐ Thyroid condition
☐ Pneumonia
☐ Blood clot (DVT)
☐ Poor circulation
☐ Phlebitis
☐ Plantar warts: hands or feet
☐ Hepatitis

☐ Liver disease
☐ Mumps
☐ Chicken pox
☐ Shingles
☐ Crohns
☐ Colitis
☐ Rashes
☐ Skin infection
☐ HIV / AIDS
☐ Lung disease

☐ Kidney disease
☐ Rubella
☐ Epilepsy
☐ Seizures
☐ Congestive Heart Failure
☐ Varicose Veins
☐ Bleeding disorder
☐ Bruise easily

☐ Headaches
☐ High / low blood pressure
☐ Mental health condition
☐ Hernia

Please check any of the following you have experienced within the past six months:

General
☐ Fatigue
☐ Allergies
☐ Difficulty Sleeping
☐ Fever
☐ Diarrhea

Eyes, Ears, Nose, Throat
☐ Sore throat
☐ Dental problems
☐ Vision impairment
☐ Ear ache
☐ Hearing difficulty
☐ Ringing in ear

Gastro-Intestinal
☐ Poor/excessive eating
☐ Vomiting
☐ Frequent nausea
☐ Excessive Thirst
☐ Weight gain/loss
☐ Constipation
☐ Heartburn
☐ Black/bloody stool
☐ Gallbladder disorders
☐ Abdominal cramps
☐ Gas/bloating with meals

Cardiovascular
☐ Chest Pain
☐ Shortness of breath
☐High blood pressure
☐ Low blood pressure
☐ Dizziness
☐ Lung disorders
☐ Chest congestion
☐ Blackouts/fainting
☐ Irregular heartbeat

Male/Female
☐ Menstrual Irregularity
☐ Breast pain/lumps
☐ Menstrual cramps
☐ Prostate enlargement

Genito-Urination
☐Painful/excessive urination
☐Bladder dysfunction
☐Urine discoloration

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Is there a family history of any of the following diseases?

- ☐ Cancer
- ☐ Anemia
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Stroke
- ☐ Heart Disease
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Psoriasis
- ☐ Eczema
- ☐ Dermatitis
- ☐ Headaches
- ☐ Mental illness
- ☐ Substance abuse
- ☐ High / low blood pressure
- ☐ Thyroid condition
- ☐ Blood clot (DVT)
- ☐ Poor circulation
- ☐ Phlebitis
- ☐ Hepatitis
- ☐ Liver disease
- ☐ Crohns
- ☐ Colitis
- ☐ HIV / AIDS
- ☐ Lung disease
- ☐ Kidney disease
- ☐ Substance abuse
- ☐ Epilepsy
- ☐ Seizures
- ☐ Congestive Heart Failure
- ☐ Varicose Veins
- ☐ Bleeding disorder
- ☐ Bruise easily
- ☐ Allergies

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Fee Schedule

Chiropractic Services

Initial Assessment : $100.00 Total

Follow-Up Treatment : $60.00 / 20 min

$70.00 / 30 min

Types of services

- Active Release Techniques (ART ®)
- Manual Therapy, Soft Tissue Mobilization
- Medical Acupuncture
- Functional Rehabilitation, Exercise Preparation
- Taping, Orthotics, Bracing

Additional Statements

Please read the following and check off each circle indicating that you agree with each statement.

Please sign below.

o I have completed all questions and areas where information has been requested. The information that I have provided is accurate and complete. I understand that the withholding of health care information could jeopardize my receiving safe and effective treatment.

o In the event I am not able to answer the phone when called by the staff of The Massage Clinic Health Centres, I hereby authorize the staff to leave a message for me regarding appointment information at the phone numbers provided.

o The team at The Massage Clinic Health Centres often collaborates with each other regarding their patients' diagnosis and treatment. In the event that this is required, I hereby consent to allowing my health care provider to collaborate with others within The Massage Clinic.

o Out of respect to our practitioners and their schedules, we require 24 hours notice for all cancellations. Any cancellations without 24 hours notice or missed appointments will be subject to a cancellation fee of the full cost of the booked appointment. This fee is applied and/or waived at the discretion of the practitioner. We appreciate your understanding.

o Chiropractic treatment may be covered under extended health insurance, and or no fault insurance such as motor vehicle accident or WSIB. However, in the event that the third party billing does not cover my treatment fees I hereby confirm that I am responsible for any outstanding balance.

o I consent to being examined by: ____

Printed Name : ________________________________ Witness Name : ________________________________

Signature: ____________________________________ Witness Signature : _____________________________

Date : ____ Date : ____