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MASSOTHÉRAPIE
Massage Addict

Chiropractic
Health History and Entrance Form

A complete health history helps us ensure it is safe to provide you with a chiropractic treatment; please let us know if your status changes so we can update your form. All information given to us is confidential.

Name ______________________ Email ______________________
We collect your email address to send you appointment reminders. Your email address will never be shared with a third party.

Home Phone ____________ Cell Phone ____________ Work Phone ____________

Street ____________ Unit ________ City ________ Prov. ______ Postal Code ______

Date of Birth (MM-DD-YY) ____________ Age ________ Occupation ____________

How did you hear about us? ______________________

Do you have insurance coverage for massage? ☐ Yes ☐ No If yes, were you referred by your doctor? ☐ Yes ☐ No

Doctor’s Name ____________ Phone ____________ Last Check-Up Date ____________

Doctor’s Street ____________ Unit ________ City ________ Prov. ______ Postal Code ______

Have you had a chiropractic treatment before? ☐ Yes ☐ No If yes, approximate date of last chiropractic treatment ________

Do you see other healthcare practitioners? ☐ Chiro ☐ Physio ☐ Naturopath ☐ Osteopath ☐ Other ________

Current Medications ______________________

Previous Major Illnesses/Operations (include dates) ______________________

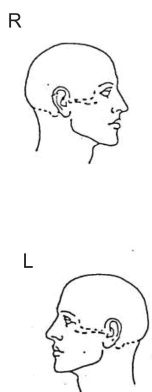
Allergies/Hypersensitivities ______________________

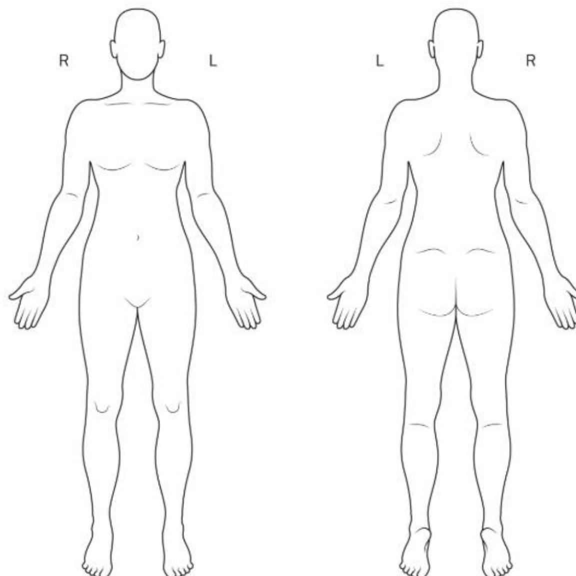
Family History of ______________________

Major Accidents (include dates) ______________________

Other Serious Medical Conditions ______________________

In the diagrams provided below, please mark the areas on your body, which you feel best represent the pain(s) or sensation(s) you are experiencing. Please include all areas. Use the symbols provided below. Please draw in the face on the diagram.





SYMBOLS:

Numbness	=======
Burning	x x x x x x
Dull & aching	? ? ? ? ? ?
Pins and Needles	ooooo
Stabbing & Sharp	~~~~~
Stiff & Tight	2 2 2 2 2

Present Symptoms: Please ✓ the box for any conditions or symptoms currently causing you problems.
Past Symptoms: Please **x** the box for any conditions or symptoms that you have had in the past.

Gastrointestinal
- ☐ Poor appetite
- ☐ Indigestion
- ☐ Excess hunger
- ☐ Belching or gas
- ☐ Vomiting
- ☐ Pain over stomach
- ☐ Constipation
- ☐ Hemorrhoids (piles)
- ☐ Jaundice
- ☐ Gall bladder trouble
- ☐ Intestinal worms
- ☐ Ulcer
- ☐ Diabetes
- ☐ Diarrhea

Neurologic
- ☐ Dizziness
- ☐ Fainting
- ☐ Problem speaking
- ☐ Problem swallowing
- ☐ Blurred vision
- ☐ Double vision
- ☐ Clumsiness
- ☐ Numbness or tingling

Cardiovascular
- ☐ Bleeding disorder
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Stroke
- ☐ Hardening of arteries
- ☐ Varicose veins
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Heart/blood disease
- ☐ Angina

Respiratory
- ☐ Asthma
- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Difficulty breathing

General Symptoms
- ☐ Loss of Consciousness
- ☐ Blackouts
- ☐ Headache
- ☐ Fever
- ☐ Excess Sweating
- ☐ Night sweats
- ☐ Loss of Weight
- ☐ Night pain
- ☐ Generalized pain
- ☐ Convulsions

Genitourinary
- ☐ Trouble urinating
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Bedwetting
- ☐ Prostate trouble

Menstrual related
- ☐ Painful menstruation
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular/absent cycle
- ☐ Cramping/backache
- ☐ Abnormal vaginal discharge
- ☐ Swollen breasts
- ☐ Lump in breasts

Have you had a bone density scan?
☐ Yes ☐ No
Currently on birth control?
☐ Yes ☐ No
Previously on birth control?
☐ Yes ☐ No
Number of pregnancies: _____
☐ Number of children: _______

Skin
- ☐ Rashes/itching
- ☐ Bruise easy
- ☐ Dryness
- ☐ Boils

Hives (allergies)

Muscles & Joints
- ☐ Sore/stiff neck
- ☐ Low back pain
- ☐ Mid back ache
- ☐ Painful tailbone
- ☐ Shoulder pain
- ☐ Arm/forearm pain
- ☐ Elbow pain
- ☐ Wrists/hand pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Ankle/foot trouble
- ☐ Arthritis
- ☐ Loss of strength

Eyes/Ears/Nose/Throat
- ☐ Failing vision
- ☐ Eye pain
- ☐ Failing hearing
- ☐ Earache
- ☐ Ring/buzz in ears
- ☐ Frequent colds
- ☐ Sinus infection
- ☐ Enlarged thyroid
- ☐ Enlarged glands
- ☐ Nervousness
- ☐ Convulsions

Have you ever had any fractures?
☐ Yes ☐ No
If yes - where?
____

Have you ever been in a car accident?
☐ Yes ☐ No
If yes - when?
____

Have you ever been hospitalized?
☐ Yes ☐ No
If yes – why/ when?
____

Have you ever been diagnosed with:
Cancer ☐ Yes ☐ No
HIV/AIDS ☐ Yes ☐ No
Hep A/B/C ☐ Yes ☐ No

Have you ever had any mental health issues?
- ☐ Depression
- ☐ Anxiety
- ☐ Nervousness
- ☐ Trauma related condition
- ☐ Substance related condition
- ☐ Personality disorder
- ☐ Bipolar disorder

Other (please list):
____
____
____
____

Medications (please list):
____
____
____
____

Clinician comments and signature:
____
____
____

Please read and sign:

- I attest that the information I have provided is true and complete to the best of my knowledge.
- I understand the information I have provided on this form is confidential and will not be released without my written consent.
- I understand that the Chiropractor can end treatment at anytime due to inappropriate behaviour.
- I consent to a health assessment/reassessments and chiropractic treatment at Massage Addict.
- I authorize Massage Addict to contact my doctor or other health care professional listed above if required for treatment purposes.
- I understand that all sessions include a pre-health assessment and change time.
- I understand 24 hours notice is required to reschedule all future appointments, or full charges will apply.
- I authorize my health file to be transferred to another Massage Addict clinic if I relocate or a new Massage Addict clinic opens closer to my household.

Signature ____________________________ Today's Date ____________________

Updates to your health history are required every 6 months. A new health history form must be filled out every year.

Changes ☐ Yes ☐ No
Comments ____________________________ Signature ____________________________

Changes ☐ Yes ☐ No
Comments ____________________________ Signature ____________________________