MASSAGE THERAPY & CHIROPRACTIC INTAKE FORM

NAME: ____________________________________ TODAY'S DATE: ___________________

DOB: _______M/_______D/_______Y PRIMARY PHONE #: _________________________

MAILING ADDRESS: ____

HOW DID YOU HEAR ABOUT US? ____

WHAT IS YOUR PRIMARY CONCERN OR REASON FOR SEEKING TREATMENT?________________

____

WHEN DID YOU FIRST NOTICE YOUR SYMPTOMS? ____________________________________

ARE YOUR SYMPTOMS A RESULT OF: Car Accident? ______ Sports Injury? _______
Work Related? ______ Other (please explain): ____________________________

ARE YOUR SYMPTOMS: Continuous? __ On & Off? __ Getting Worse? __ Getting Better? __

HAVE YOU SEEN, OR ARE YOU SEEING, ANY OTHER HEALTH CARE PRACTITIONERS FOR THIS?

____

LIST ANY ACTIVITIES OF YOUR DAILY LIVING THAT ARE AFFECTED BY YOUR SYMPTOMS:

____

WHAT HAS PROVIDED YOU WITH RELIEF? ____

ARE YOU EXPERIENCING ANY 'ASSOCIATED' PROBLEMS (eg. headaches, dizziness, numbness, visual disturbances, ringing in the ears, shortness of breath, swelling, nausea, sweating, heart palpitations, weakness, bowel problems, menstrual changes, arm/leg pain, etc):

____

LIST ANY MAJOR ILLNESSES, SURGERIES OR ACCIDENTS (INCLUDE DATES): ________________

____

LIST ANY CURRENT MEDICATIONS AND DESCRIBE WHAT THEY ARE FOR: _________________

____

ANY KNOWN ALLERGIES? ____

DO YOU FEEL YOU COULD IMPROVE ON?
Nutrition: _____ Sleep: _____ Stress: _____ Hydration: _____ Motivation: _____ Fitness: _____

ARE ANY OF THE FOLLOWING A REGULAR PART OF YOUR ROUTINE?
Alcohol: ______ Smoking: ______ Non prescription pain medications: ______ Sugar: ______
Health Supplements: ____

DO YOU GET HEADACHES? IF SO, DESCRIBE FREQUENCY, LOCATION AND CAUSE (if known):

____

ARE YOU PREGNANT OR HAVE YOU GIVEN BIRTH? ANY C-SECTIONS OR DIFFICULT LABOURS?

____

DO YOU SPEND A SIGNIFICANT AMOUNT OF TIME: Driving? ____ Sitting? ____ Computer? ____

IS EXERCISE A CONSISTENT PART OF YOUR ROUTINE? IF SO, LIST YOUR PRIMARY ACTIVITIES:

____

PLEASE RATE (1-10) YOUR MOTIVATION TO TAKE AN ACTIVE ROLE IN YOUR RECOVERY: _______

IS THERE ANYTHING ELSE YOU'D LIKE US TO KNOW? ___________________________________

____

PLEASE READ AND SIGN:

I verify that all information is correct and current to the best of my knowledge. I understand that any information provided is for safety purposes and will be kept strictly confidential, except that such information may be used by Squamish Barbell Lifting Company Inc. for statistical analysis or scientific purposes.

I acknowledge that my appointment times are reserved especially for me and include time for assessment and homecare. I agree to give 24 hours notice for any appointments that need to be rescheduled or cancelled and that cancellations within 24 hours may be subject to the full fee.

I understand that for public safety the Squamish Barbell clinic has a zero tolerance policy for symptoms of communicable illness, that I am expected to cancel my appointment if I am experiencing any symptoms of illness, and that the 24 hour cancellation fee will be waived in the occurrence of onset of symptoms including, but not limited to: fever, dry cough, tiredness, aches and pains, runny nose, sore throat, diarrhea, conjunctivitis, headache, loss of taste or smell, a rash on skin, or discolouration of fingers or toes, difficulty breathing or shortness of breath, chest pain or pressure, loss of speech or movement.

SIGNED: ____ DATE: _____________________

Print name of parent/guardian if signing for a minor under the age of 19: __________________________