Movement Chiropractic

7-3602 Taylor Street East
Saskatoon, SK S7H 5H9

MASSAGE THERAPY CONFIDENTIAL PATIENT HISTORY

NAME:_____ DATE:_____

ADDRESS:_____ CITY/TOWN:_____

PROV _____ POSTAL CODE:_____ PHONE: _____

BIRTHDATE: DD/ MM/ YY/ AGE: _____OCCUPATION:_____

WORK PHONE: _____CELL PHONE:_____

EMAIL: _____Email Appointment Reminders? ☐ Yes ☐ No

HOW DID YOU HEAR ABOUT OUR CLINIC? ☐ WEBSITE ☐ GOOGLE ☐ REFERRED BY: _____

Please complete this questionnaire.

Chiropractor:_____ Physiotherapist:_____

Family Doctor: _____ Last Physical:_____

Have you received massage therapy before?_____ If so when?_____

Is this a SGI Claim?

☐ Yes ☐ No If so, Claim #_____Adjustor:_____ Accident Date:_____

Is this a WCB Claim?

☐ Yes ☐ No If so, Claim #_____Case Manager:_____Injury Date:_____

Lifestyle Questions

Current sleeping patterns:_____

Exercise/Activities:_____

Eating Habits (food groups, meals per day)_____

Alcohol/Tobacco Intake (daily/weekly)_____

Have you been treated by any of the following in the past two years?

☐ Chiropractor ☐ Physiotherapist ☐ Naturopath ☐ Massage Therapist ☐ Other

For what condition(s)?_____

Special Notes/Other (pins, wires, artificial joint/limbs, special equipment):

_____

Do you suffer from stress ☐ Yes ☐ No

What are your stress symptoms?_____

On a pain scale of 1 to 10, with 1 being the least amount of pain and 10 being the most amount of pain, what do you rate your pain level?_____

Are you presently taking medications (including over-the-counter) or natural remedies?

☐ Yes ☐ No If so, please list:_____

_____

Surgery/Injury:

Date:_____

Type:_____

Current Symptoms:_____

_____

Current Condition Treated:

_____

_____

Health History: please check the conditions that you experience frequently:

Muscular/Skeletal
- □ Headache type:_____
- □ Neck Pain
- □ Shoulder Pain
- □ Mid Back Pain
- □ Lower Back Pain
- □ Limited Movement
- □ Muscle Cramps/Spasms
- □ Arthritis
- □ Scoliosis
- □ Dislocation
- □ Difficulty Walking

Male Reproductive System
- □ Prostate Problems
- □ Cancer

Female Reproductive System
- □ Menstruation Problems
- □ Pregnant Estimated Due Date:_____
- □ Endometriosis
- □ Menopause
- □ Cancer

Respiratory/Circulatory
- □ Dizziness/Fainting Spells
- □ Tingling in lips/fingers
- □ Chest Pains
- □ Shortness of Breath
- □ Asthma
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Allergies _____
- □ Varicose Veins
- □ Sinus Problems

Psychological/Nervous System
- □ Anxiety
- □ Depression
- □ Nervousness
- □ Unexplained/Sudden Weakness
- □ Insomnia

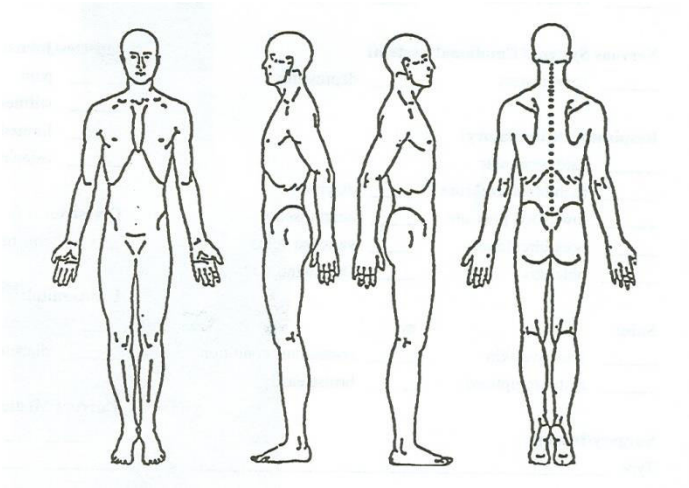
Gastrointestinal
- □ Diarrhea
- □ Ulcers
- □ Constipation

Uro/Genital
- □ Frequent Urination
- □ Diabetes
- □ Kidney/Bladder Infections

Integument (skin)
- □ Acne/Cysts
- □ Contagious Condition
- □ Psoriasis
- □ Eczema
- □ Bruise Easily

Other:_____
_____
_____
_____

Please mark on the diagrams below, your areas of pain/discomfort:



The information contained on this form is true to the best of my knowledge. I give my consent that my therapist may obtain and submit reports regarding my condition to/from my physician as may be required.

Signed_____ Date:_____