Norwood
Chiropractic Centre

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Massage Therapy Initial Patient Form

INFORMATION ABOUT YOU: Date: ______________

First Name: ______________________ Last Name: _________________________

Birthday (dd/mm/yyyy) ____/____/_______ Current Age: ______

Street Address: ____

City: _________________________ Province: __________ Postal Code: ________

Home #: _____________ Cell: _____________ Emergency: __________________

Email address: _____________________________

Occupation: ______________________________

Are you pregnant: ☐ Yes ☐ No

Who can we thank for referring you to our office? ____

Do you have extended health insurance? : Yes / No (If you have provided us your card you may skip)

Insurance provider: __________________ plan #:_____________________ ID #:__________________

MAJOR HEALTH CONCERN

What condition brought you to our office? ____

____

On a scale of 1-10 (10 being severe), how bad is the problem? ____/10
When did it start? ______________________ How? ____________________________________
Is it ☐ getting better ☐ getting worse ☐ staying the same?
How would you describe the problem? ____
Are you taking medication for this condition? ☐ Y ☐ N
If yes, which medication: ____ Dose: ___

Please list ALL other medications and/or surgeries: ____

Please list any skin conditions: ____

Please list any neurological conditions: ____

Health History
Please mark '**X**' for present conditions, '**O**' for past conditions

- ☐ Headache
- ☐ Migraine
- ☐ Jaw Pain/TMJ/RL
- ☐ Numb/Tingling in hand/arm
- ☐ Upper back pain
- ☐ Shoulder pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Hip Pain
- ☐ Numb/Tingling in leg/feet
- ☐ Foot Pain
- ☐ Scoliosis
- ☐ Arthritis
- ☐ Diabetes
- ☐ Swollen/Painful Joints
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Trouble
- ☐ Stroke
- ☐ Crohn's Disease
- ☐ Hepatitis (A, B, C)
- ☐ HIV/AIDS
- ☐ Sinus Problems
- ☐ Dizziness
- ☐ Loss of Balance
- ☐ Ulcers
- ☐ Epilepsy
- ☐ Osteoporosis
- ☐ Hernia
- ☐ Breathing Problems
- ☐ Varicose Veins
- ☐ Cancer

Any other condition's not listed? ____

Do you have a history of whiplash or previous MVA? ☐ Y ☐ N: ______________________

Consent to Massage Therapy

All patient information is confidential and subject to the Personal Health Information Act (PHIA) and will not be released without signed consent by the patient.

If you need to cancel a session please call with 24 hours notice or more so we can offer your appointment to another client. If you are unable to cancel your appointment with 24 hours notice you will be charged a fee of $30.

I ______________________, do hereby grant the registered massage therapist, permission to provide massage therapy treatment to me as discussed. I understand that I may refuse, alter, or rescind at any time. I understand that the charges of the above mentioned treatment may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to Norwood Chiropractic Centre for the cost of the treatment or cancellation fee.
The Information on this form is true to the best of my knowledge.

Signature: ______________________ Date: ______________________