



**HEALTH
MATTERS
CHIROPRACTIC
CENTRE**

Defining health to enhance life.
Chiropractic, Registered Massage Therapy and Acupuncture

3175 Rutherford Road, Suite 57, Vaughan, Ontario L4K 5Y6
Tel: (905) 532 0410 Fax: (905) 532 0413
Website: www.enhancelife.ca

An accurate health history is important to ensure that it is safe for you to receive massage treatment. If your health status changes in the future, please let us know. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis or treatment. You will be asked to provide written authorization for release of any information.

MASSAGE THERAPY INTAKE FORM

Patient #: _____

Personal History

Date: _____

Name: _____

First Initial Last

Address: _____

Street Apt. City Province Postal Code

Home phone: (____) _____ Cell phone: (____) _____ Bus. phone: (____) _____ X

e-mail _____ Would you like to receive newsletters and updates via email: Y N

Birthdate: (dd/mm/yyyy) _____ Age: _____ Sex: M F Massage experience: Y N

Business/Employer _____ Extended Health Coverage: Y N AMT: _____

Type of Work: _____ **Circle one:** Married Single Divorced Separated Other

Name and number of emergency contact: _____

Referred to us by?: _____

Current Health Condition:

What is your primary complaint?: _____

Other Health Professional seen for this condition: Y N Who? _____

What is your general health status? _____

Please check the conditions that you are currently experiencing, or have experienced often in the past.

Head/Neck

- headaches
- type: _____
- vision problems
- contact lenses
- earaches

Skin

- skin conditions
- type: _____
- bruise easily

Medical Doctor

Name: _____
Phone: _____
Date of last visit: _____

Respiratory

- chronic cough
- shortness of breath
- smoking
- breathing problems
- type: _____

Other Conditions

- difficult digestion
- constipation
- liver _____
- gall bladder _____
- kidney _____
- bladder _____
- diabetes- onset _____
- sinus
- allergies _____
- insomnia
- cancer _____
- arthritis
- Dr. diagnosed? Y N
- affected areas _____

Current Medications

Name	For what condition?
_____	_____
_____	_____
_____	_____

Cardiovascular

- high blood pressure
- low blood pressure
- poor circulation
- heart disease
- phlebitis
- stroke
- varicose veins

Other Healthcare

- Chiropractic
- Physiotherapy
- Psychotherapy
- Regular exercise
- Massage

Muscle (pain and stiffness)

- Neck
- Low back
- Mid back
- Upper back
- Shoulder
- Leg: L / R
- Knee: L / R
- Other _____

Surgery

type: _____
date: _____
current symptoms: _____

Infections

- herpes
- hepatitis
- plantar warts
- TB
- HIV, AIDS
- Other: _____

Women

- menstrual problems painful
- caesarian section or other gynecological surgery
- _____
- Pregnant: due date: _____
- Children: number _____

Injury

type: _____
date: _____
current symptoms: _____

Other medical conditions ?

Of special note: (pins, wires, artificial joints or limbs)