RIVER OAKS CHIROPRACTIC & WELLNESS CENTRE

MASSAGE THERAPY PATIENT HISTORY

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

NAME: _____ D.O.B: _____ TODAY'S DATE: _____ FILE NO.:_____
ADDRESS:_____ POSTAL CODE:_____
OCCUPATION:_____ EMAIL: _____
TEL.: _____ TEL.: _____
(home) (cell)
Have you received massage therapy before? □ Yes □ No Date of last massage: _____
Did a health care practitioner refer you for massage therapy? □ Yes □ No
If yes, please provide their name and address. _____
_____

Please indicate conditions you are experiencing or have experienced:

CARDIOVASCULAR
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Chronic congestive heart failure
- □ Heart attack
- □ Phlebitis / varicose veins
- □ Stroke / CVA
- □ Pacemaker or similar device
- □ Heart disease

Is there a family history of any of the above? □ Yes □ No

RESPIRATORY
- □ Shortness of Breath
- □ Chronic Cough
- □ Asthma
- □ Emphysema
- □ Bronchitis

Is there a family history of any of the above? □ Yes □ No

INFECTIONS
- □ Tuberculosis
- □ HIV/AIDS
- □ Hepatitis
- □ Skin conditions
- □ Herpes
- □ Other _____

OTHER
- □ Loss of sensation, where? _____
- □ Diabetes, onset: _____
- □ allergies / hypersensitivity to what? _____
- □ Epilepsy
- □ Cancer, where? _____
- □ Skin conditions, what? _____
- □ Arthritis

Is there a family history of arthritis? □ Yes □ No

HEAD/NECK
- □ History of headaches
- □ History of migraines
- □ Vision problems
- □ Vision loss
- □ Ear problems
- □ Hearing loss

WOMEN
- □ Pregnant: due _____
- □ Gynecological conditions, what? _____

Overall, how is your general health? _____

Primary Care Physician: _____

Address: _____
_____

Current Medications: _____

Conditions it treats: _____
_____

Are you currently receiving treatment from another health care professional? □ Yes □ No
If yes, for what? _____
_____

Surgery—date _____
Nature: _____

Injury—date _____
Nature: _____

Do you have any other medical conditions? (e.g. osteoporosis, mental illness) □ Yes □ No
What? _____

Do you have any internal pins, wires, artificial joints or special equipment? □ Yes □ No
what?_____
where? _____

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort.
_____
_____

Extra Notes:
_____
_____
_____
_____
_____

Date of Initial Health History:
Update 1 _____
Update 2 _____
Update 3 _____
Update 4 _____

RIVER OAKS CHIROPRACTIC & WELLNESS CENTRE

Newsletters

Our clinic newsletter, which includes office updates and articles from our various practitioners, is sent by email twice a year. If you would like to receive our newsletter, please fill in your email:

Email: _____ (please print clearly)

You can opt out of receiving our clinic newsletter by email at anytime by following the directions enclosed when you receive the newsletter. We will not use your email for any marketing or spam purposes. We appreciate your consent to send our newsletter by email in order to be more environmentally friendly.

_____ _____

Patient Name Patient Signature

Date: M / D / Y

Short Notice Appointment Eblast

On occasion we have patients who cancel their appointments last minute on the day of their appointment. When this happens we will send out an email to all patients who have agreed to this short notice appointment availability eblast to let you know of this availability. The appointment that has become available will be filled on a first contact basis, so whomever responds back first from our eblast for the appointment will get it. You are not obligated in anyway to take the appointment that has become available, but it does offer an option to get in with our registered massage therapist quickly during high peak times. If you would like to receive this eblast please fill in your email below:

Email: _____ (please print clearly)

_____ _____

Patient Name Patient Signature

Date: M / D / Y

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