PARALLEL CHIROPRACTIC & WELLNESS CENTRE
Patient Entrance Form – Massage Therapy

Patient Name: _____ Date: _____

Home Address: _____City_____ Postal Code: _____

Cell/Phone #: _____Work #: _____ Occupation:_____

Date of Birth: (M)____(D)____(Yr)_____ Height:_____ Weight_____

E-Mail:_____ As per CASL I consent to receive emails from you_____(Initial)

Were you referred to this clinic? Y__N__ If yes, by whom:_____

Medical Doctor: _____ Phone: _____

Reason for consulting this clinic:_____

Health History – Please list symptoms you are presently experiencing

General
- □ Chills
- □ Depression
- □ Dizziness/Faint
- □ Nervousness
- □ Numbness
- □ Sweats
- □ Sleep Deprivation
- □ Weight Loss
- □ Arthritis
- □ Allergies

_____
_____

Muscle/Joint/Bone
- □ Arms
- □ Neck
- □ Shoulders
- □ Upper Back
- □ Lower Back
- □ Hips
- □ Legs
- □ Knees
- □ Feet
- □ TMJ

Cardiovascular
- □ Diabetes
- □ Heart Disease
- □ Stroke (TIA)
- □ Chest Pain
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Irregular Heart Beat
- □ Rapid/Slow Heart Rate
- □ Poor Circulation
- □ Smoking
- □ Varicose Veins

Gastrointestinal
- □ Poor Appetite
- □ Bloating
- □ Bowel Changes
- □ Constipation
- □ Diarrhea
- □ Excessive Hunger
- □ Excessive Thirst
- □ Gas
- □ Indigestion
- □ Nausea/Vomiting
- □ Stomach Pain

Genito-Urinary
- □ Frequent Urination
- □ Lack of Bladder Control
- □ Painful Urination

Head/Neck
- □ Sinus Problems
- □ Asthma
- □ Persistent Cough
- □ Difficulty Swallowing
- □ Earaches
- □ Hearing Loss
- □ Ringing in Ears
- □ Nosebleeds
- □ Vision – Flashes/Halo
- □ Contact Lenses
- □ Headaches
  - □ Tension
  - □ Migraines

Women Only
- □ Breast lump
- □ Menstrual Problems
- □ Hot Flashes
- □ Painful Intercourse
- □ Other

Have you had a mammogram_____
Are you pregnant_____
Number of children____

Date of last Physical
_____

Please List Current Medications
_____
_____
_____
_____

Other Healthcare
_____
_____
_____

Please list any illnesses or surgeries and their dates_____
_____

Please list any accidents and their dates_____
_____

REASON FOR CONSULTING THIS CLINIC:

1)____ I have a specific problem and require help only with this problem.
2)____ I am interested in strategies to insure the problem does not return.
3)____ I am interested in strategies to improve my overall health.

(over)

What is your major complaint? _____

How long have you had this condition? _____

How did this condition occur? _____

Have you had a similar condition in the past? _____

What activities aggravate your condition? _____

Is this condition interfering with your 1)Work?_____ 2)Sleep?_____ 3)Daily Routine?_____

How long has it been since you really felt good? _____

On a scale of 1 – 10 describe your stress level (1=none / 10=severe)

Occupational _____ Personal _____

On a scale of *Poor, Fair, Good,* and *Excellent,* describe your:

Diet_____ Exercise_____ Sleep_____ General Health_____

Using an 'X', mark on the line below where you would best describe your pain level today
No Pain [____.____.____.____.____.____.____.____.____.____.____] **Worst Pain**

I have stated all of my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health. All information in the clinic file is confidential except as required by law. I am aware that the other health care practitioners of whom I am a patient at Parallel Chiropractic and Wellness Centre will have access to the information in my clinic file.

I understand that payment is expected at the time of my visit, and that if I fail to **cancel an appointment the day before**, I will be charged for the missed appointment. *Please be on time for your appointment, arriving late will shorten your actual treatment time.*

Signature_____ Date_____