

WOODBRIDGE AVENUE CHIROPRACTIC AND WELLNESS CENTRE
 53 WOODBRIDGE AVENUE, UNIT 4
 WOODBRIDGE, ON, L4L 9K9
 P: 905-264-8107 F: 905-264-8542

PATIENT INFORMATION			DATE:	
FIRST NAME	LAST NAME		GENDER <input type="checkbox"/> M <input type="checkbox"/> F	
ADDRESS	APT	CITY	PROV	POSTAL CODE
HOME PHONE	CELL PHONE	DATE OF BIRTH (DD/MM/YYYY)		
EMAIL ADDRESS			OCCUPATION	
MARITAL STATUS: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Other				
EMERGENCY CONTACT: Name		Telephone		Relationship
FAMILY DOCTOR: Name			Telephone	
HOW DID YOU HEAR ABOUT US?				

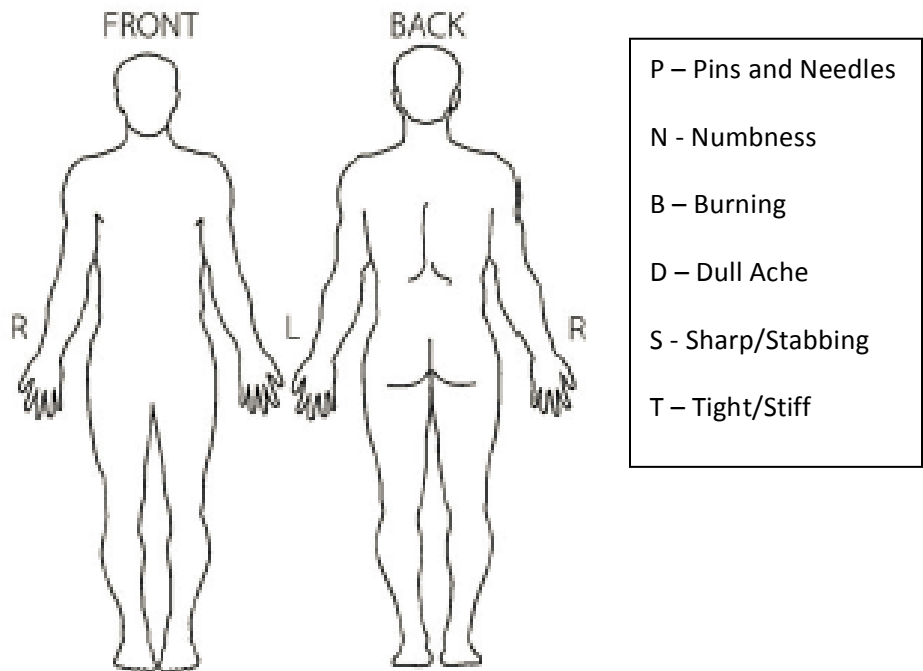
HEALTH INFORMATION		
Please list your medical conditions: _____ _____ _____ _____ _____	Medications: _____ _____ _____ _____ _____	Allergies: _____ _____ Alcohol: <input type="checkbox"/> Yes <input type="checkbox"/> No Smoking: <input type="checkbox"/> Yes <input type="checkbox"/> No Regular exercise: <input type="checkbox"/> Yes <input type="checkbox"/> No Hours of sleep /night: _____ Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Due date: _____
Previous surgeries and year:		
Accidents/Injuries/Fractures:		
☐TYPE	YEAR	AREA OF INJURY _____
☐TYPE	YEAR	AREA OF INJURY _____
☐TYPE	YEAR	AREA OF INJURY _____

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS OR ANY OF THE FOLLOWING SYMPTOMS REGULARLY
<input type="checkbox"/> loss of consciousness <input type="checkbox"/> dizziness <input type="checkbox"/> numbness/tingling <input type="checkbox"/> weakness <input type="checkbox"/> frequent headaches <input type="checkbox"/> vision change <input type="checkbox"/> choking/trouble swallowing <input type="checkbox"/> seizures <input type="checkbox"/> history of stroke <input type="checkbox"/> hearing loss
<input type="checkbox"/> shortness of breath <input type="checkbox"/> asthma <input type="checkbox"/> bronchitis <input type="checkbox"/> emphysema
<input type="checkbox"/> chest pain <input type="checkbox"/> atherosclerosis/vascular disease <input type="checkbox"/> history of heart attack <input type="checkbox"/> aneurysm <input type="checkbox"/> diabetes <input type="checkbox"/> high blood pressure <input type="checkbox"/> high cholesterol
<input type="checkbox"/> loss of bowel/bladder function (<input type="checkbox"/> stool <input type="checkbox"/> urine) <input type="checkbox"/> prostate problems <input type="checkbox"/> kidney stones <input type="checkbox"/> difficulty with urination (difficulty starting stream, burning, blood in urine)
<input type="checkbox"/> abdominal pain <input type="checkbox"/> vomiting/diarrhea <input type="checkbox"/> gastric/duodenal ulcer <input type="checkbox"/> pancreas problems <input type="checkbox"/> liver disease
<input type="checkbox"/> osteoarthritis <input type="checkbox"/> rheumatoid arthritis <input type="checkbox"/> scoliosis <input type="checkbox"/> ankylosing spondylitis <input type="checkbox"/> osteoporosis
<input type="checkbox"/> recurrent fevers <input type="checkbox"/> drenching night sweats <input type="checkbox"/> weight loss
<input type="checkbox"/> history of cancer - type:
<input type="checkbox"/> skin conditions:
<input type="checkbox"/> infections: <input type="checkbox"/> HIV <input type="checkbox"/> tuberculosis <input type="checkbox"/> herpes <input type="checkbox"/> hepatitis
<input type="checkbox"/> internal objects/devices: <input type="checkbox"/> pacemaker <input type="checkbox"/> metal/pins <input type="checkbox"/> artificial joints <input type="checkbox"/> Where?
Women: <input type="checkbox"/> painful periods <input type="checkbox"/> excessive flow <input type="checkbox"/> cramping <input type="checkbox"/> hot flashes

PLEASE CHECK IF THERE IS A FAMILY HISTORY OF THE FOLLOWING CONDITIONS AND SPECIFY FAMILY MEMBER	
<input type="checkbox"/> osteoarthritis	<input type="checkbox"/> rheumatoid arthritis
<input type="checkbox"/> heart attack	<input type="checkbox"/> cancer
<input type="checkbox"/> stroke	<input type="checkbox"/> diabetes
<input type="checkbox"/> other	

MESSAGE INFORMATION
What is the reason for seeking care today:
Is this related to: <input type="checkbox"/> Recent motor vehicle accident <input type="checkbox"/> Work-related injury/accident (WSIB)
Have you had an xray for this problem? <input type="checkbox"/> Yes <input type="checkbox"/> No When?
Have you seen a massage therapist before for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No

PLEASE MARK ALL THE AREAS OF THE BODY WHICH YOU FEEL ARE PAINFUL OR PROBLEMATIC USING THE LETTER KEY BELOW:



PATIENT'S DECLARATION

All of the above health information is complete and correct to the best of my knowledge. I understand that omitting health information may be dangerous to my health.

Signature _____ Date _____.

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the Massage Therapist Association.

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

In compliance with the "consent to treatment act" College of Massage Therapist Code of Ethics, I provide my full voluntary informed consent to be treated by:

Lisa Hawley, Registered Massage Therapist

Angela Parsons, Registered Massage Therapist

Patient Name _____ Signature of Patient/Guardian _____

Witness _____ Date Signed _____