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 ◻ M ◻ F
ADDRESS		APT	CITY		PROV	POSTAL CODE
HOME PHONE	CELL PHONE		DATE OF BIRTH (DD/MM/YYYY)			
EMAIL ADDRESS				OCCUPATION		
MARITAL STATUS: ◻ Married ◻ Single ◻ Divorced ◻ 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: ◻Yes ◻ No
Smoking: ◻Yes ◻ No
Regular exercise: ◻Yes ◻No
Hours of sleep /night: ________________.
Are you pregnant? ◻Yes ◻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

◻ loss of consciousness ◻ dizziness ◻ numbness/tingling ◻ weakness ◻ frequent headaches
◻ vision change ◻ choking/trouble swallowing ◻seizures ◻ history of stroke ◻ hearing loss

◻ shortness of breath ◻asthma ◻bronchitis ◻ emphysema

◻ chest pain ◻atherosclerosis/vascular disease ◻history of heart attack ◻ aneurysm
◻ diabetes ◻high blood pressure ◻high cholesterol

◻ loss of bowel/bladder function (◻stool ◻urine) ◻prostate problems ◻kidney stones
◻ difficulty with urination (difficulty starting stream, burning, blood in urine)

◻ abdominal pain ◻vomiting/diarrhea ◻gastric/duodenal ulcer ◻pancreas problems ◻ liver disease

◻ osteoarthritis ◻rheumatoid arthritis ◻scoliosis ◻ ankylosing spondylitis ◻osteoporosis

◻ recurrent fevers ◻ drenching night sweats ◻ weight loss

◻ history of cancer - type:

◻ skin conditions:

◻ infections: ◻HIV ◻ tuberculosis ◻ herpes ◻ hepatitis

◻ internal objects/devices: ◻ pacemaker ◻ metal/pins ◻ artificial joints ◻*Where?*

Women: ◻painful periods ◻excessive flow ◻cramping ◻hot flashes

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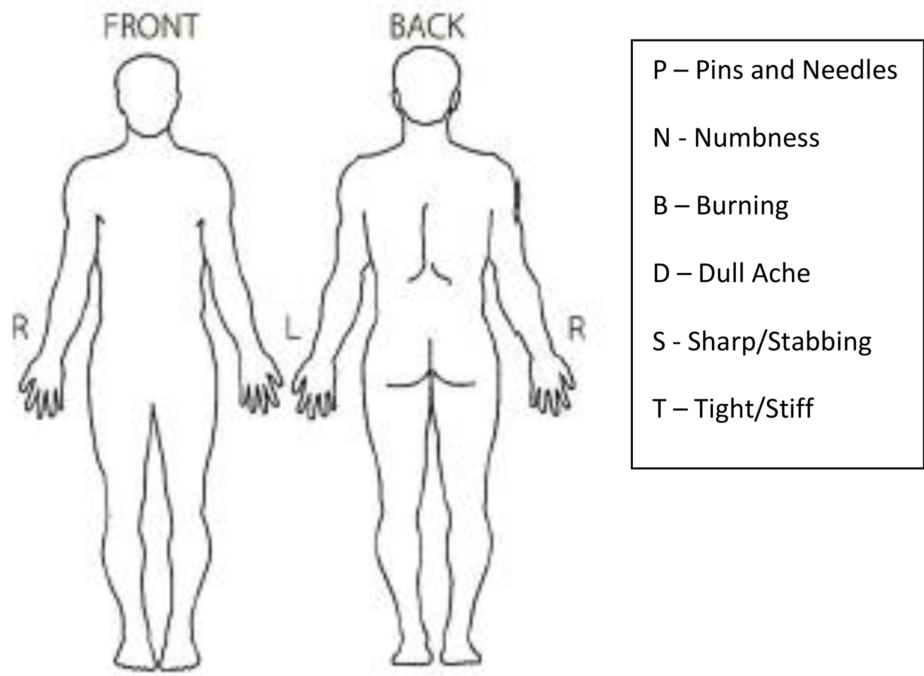
PLEASE CHECK IF THERE IS A FAMILY HISTORY OF THE FOLLOWING CONDITIONS AND SPECIFY FAMILY MEMBER	
□ osteoarthritis	□ rheumatoid arthritis
□ heart attack	□ cancer
□ stroke	□ diabetes
□ other	

MASSAGE INFORMATION
What is the reason for seeking care today:
Is this related to: □ Recent motor vehicle accident □ Work-related injury/accident (WSIB)
Have you had an xray for this problem? □Yes □ No When?
Have you seen a massage therapist before for this condition? □Yes □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________________________.

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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

Enas Ibrahim Ali, Registered Massage Therapist

Patient Name ____________________ Signature of Patient/Guardian _________________

Witness _________________________________ Date Signed _____________________