# MASSAGE PATIENT ENTRANCE FORM

Cranbrook Chiropractic & WELLNESS CENTRE

Date:_____, 20_____

Name _____ Gender: _____

Mailing Address_____

City _____ Province_____ Postal Code_____

BC Health Care #_____ Extended Medical Insurer (ex:SunLife)_____

Home Tel#_____ Cell#:_____Email:_____

Date of Birth (M/D/Y)_____Age:_____ Height: _____(ft) Wt:_____ (lbs)

Occupation:_____Employer:_____ Bus Tel#:_____

**Reminders**: □Text □Email □Neither

**Emergency Contact**: Name_____ Relationship_____ Tel#_____

**How did you hear about our office?** _____

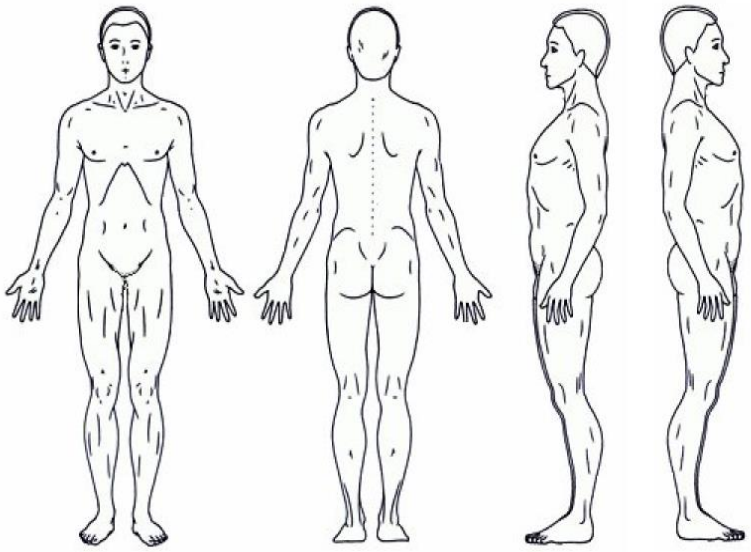
ICBC OR WCB CLAIM? No□ Yes □ If Yes, Claim #_____

Reason for Consulting this office:_____
How long have you been experiencing this? _____

Have you felt this before? No□ Yes □ When?_____ Chronic ongoing□ Chronic on/off□

What makes it **better**? _____What makes it **worse**? _____

Show the area(s) of pain or unusual feeling. Mark the areas using the legend provided.



Numbness ●●●●

Pins/Needles 0000

Burning xxxx

Aching ****

Stabbing //////

**Put an "X" to indicate the intensity.**

0 1 2 3 4 5 6 7 8 9 10
|_____|
**No Pain** **Severe Pain**

Have you ever had any of the following? Please check of the box where applicable.

| | | | | | |
|---|---|---|---|---|---|
| Aneurysm | ☐ | Epilepsy | ☐ | Asthma | ☐ |
| Osteoporosis | ☐ | Cancer | ☐ | Psoriasis | ☐ |
| Diabetes | ☐ | Strokes | ☐ | Sinus Conditions | ☐ |
| Arthritis | ☐ | Allergies | ☐ | Bursitis | ☐ |
| Respiratory Conditions | ☐ | Heart Conditions | ☐ | Other _____ | ☐ |
| Hepatitis | ☐ | Nervousness | ☐ | Pain Between shoulder | ☐ |
| Fatigue | ☐ | Polio | ☐ | Pain with Feet | ☐ |
| Sleeping Difficulties | ☐ | Pneumonia | ☐ | Lower Back Pain | ☐ |
| Arthritis | ☐ | HIV | ☐ | Headaches | ☐ |
| Sciatica | ☐ | Swollen Joints | ☐ | Neck Pain/Stiffness | ☐ |
| High/Low Blood Pressure | ☐ | Irritable Bowel/Colitis | ☐ | | ☐ |

Please include any information you feel is pertinent on any items checked off above

_____
_____
_____
_____

Do you smoke? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

Have you had any surgery or operations? If yes, please list _____

List any medication or drugs you are currently taking: _____

Falls and Accidents? If yes, please list: _____

**Have you had previous Massage Therapy?** No□ Yes □ Last Treatment Date_____

**Family Doctors Name** _____ Last Appointment (roughly)?_____

Do you see any other health care professionals? (physio, chiro, acupuncture, naturopath)?

Please List _____

**Informed Consent to Treatment**

This is to confirm and acknowledge that the above mentioned information is correct and accurate to my knowledge and that I give consent for my treatment by a Registered Massage Therapist. I also acknowledge that appointments must be cancelled **24 hours prior to scheduled time** or a **$50 "Missed Appointment" fee** may be applied.

**SIGNATURE_____ DATE_____**