ATLAS CHIROPRACTIC & BODY BALANCE

#4-4515 Uplands Dr. Nanaimo, BC V9T 6M8

Massage Patient History Form

Name _____ **Date:** _____

Birthdate _____ **Address** _____

(month/day/year) _____

Care Card # _____

Postal Code _____

Phone (home) _____

(cell) _____

(work) _____

Email _____

Occupation _____

How did you hear about (Registered) Massage Therapy? _____

How did you hear about our clinic? _____

Please indicate if you believe if any of the following apply to you? (P= past C= current) Circle if necessary.

_ Heart Attack
_ High / Low Blood Pressure
_ Stroke or Aneurysm
_ Pace Maker
_ other Heart condition
_ Varicose Veins
_ Bruise easily
_ other Circulatory condition

_ Diabetes
_ Kidney Disease
_ other Urinary condition

_ Headaches / Migraines
_ Dizziness / Fainting
_ Nausea
_ Spinal Injury
_ Head Injury
_ Epilepsy / other seizures
_ other Neurological conditions

_ Asthma
_ Chronic Sinusitis
_ other Respiratory condition

_ Irritable Bowel / Colitis
_ Digestive condition
_ Skin condition

_ Joint Dislocation
_ Bone Fracture
_ Arthritis
_ Osteoporosis
_ Rods / Pins / Plates / Shunts
_ Implants _____
_ Transplant _____
_ Corrective Lenses / Contacts

_ Cancer _____
_ Hepatitis
_ HIV
_ other Contagious condition
_____

Please list any Medications you presently take:

_____

_____

Known Allergies (including medications, foods, seasonal, oils and lotions, etc.)

_____

Do you have any family history of medical conditions? □**Yes** □ **No**

Please list: _____

Have you ever been hospitalized, had any major accidents, illnesses or surgeries? □ **Yes** □ **No**

Please comment: _____

Other therapy / treatment: (past or present, does not have to be related to this visit)

□ Massage Therapy	Date of last visit _____	Location _____
□ Chiropractic	" _____	" _____
□ Physiotherapy	" _____	" _____
□ Naturopath	" _____	" _____
□ Acupunture	" _____	" _____
□ Other _____	" _____	" _____

List any Activities, Sports, Hobbies
(i.e. Jogging, Hockey, Crafts, Computer, etc.)

_____

_____

_____

List any **NON-prescription vitamins, minerals or other supplements** you are taking:

_____

_____

_____

Please CIRCLE the answer closest to how you PRESENTLY feel: (1 = poor 5 = excellent)

Quality of Sleep	1	2	3	4	5
Energy Level	1	2	3	4	5
Eating Habits	1	2	3	4	5
Stress Level	1	2	3	4	5
Exercise Habits	1	2	3	4	5

Hours of sleep per night (approx.) _____

Number of meals you regularly eat per day _____

Number of times you exercise per week _____

Smoker	Yes	No	Occasional
Alcohol	Yes	No	Occasional

Current Condition

Please describe your current condition & symptoms: _____

_____

_____

_____

How long have you had this condition? _____

How did it start? _____

_____

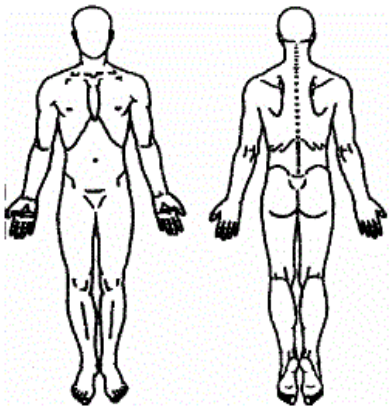
What aggravates it? _____

_____

What relieves it? _____

_____

Please indicate on the diagram the nature of your symptoms, using the symbols indicated:



Aching	O O
Stabbing	X X X
Shooting	→ →
Burning	# # #
Numbness or Tingling	≈≈ ≈≈

Please Note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

I authorize the clinic and its associated RMTs to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated RMTs to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature: **Date:**