Massage Therapy

File No: _____

Waterdown Village Chiropractic Group

5 Mill Street South
Waterdown, ON L0R 2H5
T 905·689·4440
F 905·689·4441
E info@wvchirogroup.ca

wvchirogroup.ca

Dr. Cheryl van der Mark BSc, DC, FICPA
Clinic Director

General Information

How do you wish to be addressed in our office?

☐ **First name** ☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms** ☐ **Dr**

How do you wish to be contacted by our office? ☐ **Email** ☐ **Text** ☐ **Phone**

Name:

Last: _____ **D.O.B.** _____

First: _____

Address: _____

Town/City: _____ **Province:** _____ **Postal Code:** _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Email: _____ _____ **Please Initial** Expressed consent to receive email communication from the clinic

Occupation: _____ **Spouse's name (if applicable):** _____

Referred by: _____

How did you decide to choose our office? _____

Health Information:

Family Dr. Name: _____ **Address:** _____

Previous Chiropractic Care? Y N If Yes, Doctor's name: _____

List other therapies (i.e. physiotherapy): _____

Have you ever received a professional massage? Y N

Are you pregnant? Y N How many weeks? _____

Personal Information and Privacy Policy:

All personal information remains protected and confidential and will not be released without your previous written consent. I may view the Waterdown Village Chiropractic Group privacy policy in full at any time.

Massage Therapy

File No: _____

HEALTH HISTORY: (please check all that apply)

Musculoskeletal
- ☐ Bone or joint disease
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Fractures
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Sprains/strains
- ☐ Low back/hip/leg pain
- ☐ Neck/shoulder/arm pain
- ☐ Headaches/head injuries
- ☐ Migraines
- ☐ Jaw pain/TMJ Syndrome
- ☐ Spasms/cramps
- ☐ Other: _____

Skin
- ☐ Allergies/skin irritation
- ☐ Rashes/infections
- ☐ Athletes' Foot
- ☐ Warts
- ☐ Other: _____

Infectious Disease
- ☐ Hepatitis (Type: ___)
- ☐ TB
- ☐ HIV
- ☐ Other: _____

Circulatory
- ☐ Heart disease
- ☐ Varicose veins
- ☐ Blood clots
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Lymphedema
- ☐ Breathing difficulty
- ☐ Sinus problems
- ☐ Allergies
- ☐ Anaphylaxis
- ☐ Chronic congestive heart failure
- ☐ Myocardial infarction
- ☐ Stroke
- ☐ Phlebitis
- ☐ Hemophilia
- ☐ Pacemaker
- ☐ Other: _____

Nervous System
- ☐ Herpes/shingles
- ☐ Numb/tingling
- ☐ Loss of sensation
- ☐ Chronic pain
- ☐ Fatigue
- ☐ Sleep disorder

Digestive
- ☐ Constipation
- ☐ Gas/bloating
- ☐ Diverticulitis
- ☐ Irritable Bowel Syndrome
- ☐ Chron's/Colitis
- ☐ Other: _____

Respiratory
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Asthma
- ☐ Other: _____

Other
- ☐ Cancer
- ☐ Depression
- ☐ Drug/alcohol addiction
- ☐ Nicotine/caffeine addiction
- ☐ Diabetes (type: _____)
- ☐ Hearing loss
- ☐ CFS/Fibromyalgia
- ☐ Allergies to oils
- ☐ Other: _____

Current Medications: _____

Surgeries (please list and date): _____

Injuries/Accidents still affecting daily activities (please list): _____

_____

Do you have any internal pins, wires, artificial joints or special equipment? Y N

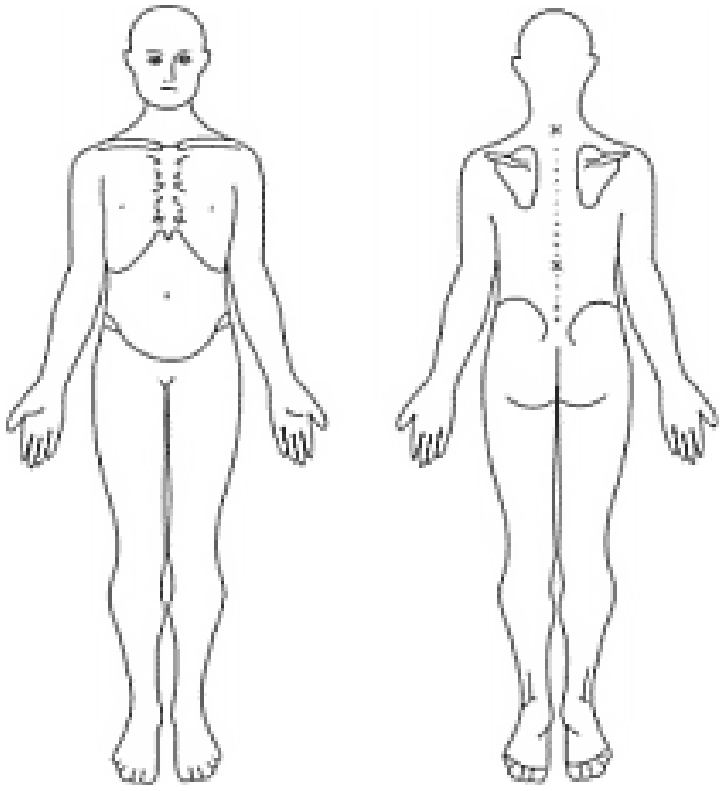
General Health Status (please circle one): POOR AVERAGE GOOD EXCELLENT

Massage Therapy

File No: _____

Name_____

Please indicate with an 'X' any areas on the figure where you are experiencing pain. Please shade any areas you experience tension or discomfort.



Consent:

It is my choice to receive massage therapy. I am aware that an assessment may be necessary. Removal of all articles of clothing is not required for treatment, and I will remove only the clothing I am comfortable with. I am aware that I may experience side effects such as temporary discomfort within the muscles, bruising or temporary dizziness. I understand that I may alter or terminate my treatment at any point.

Signature: _____ **Date: _____**
(18 years of age or older)

Parental/Guardian Signature: _____ Date: _____