City View Chiropractic
Sports Injury & Therapeutic Exercise

# MASSAGE INTAKE FORM

## MEDICAL HISTORY

I understand that the information that I give on this form will be confidential and will be used for no other purpose than for the professional therapist's records & I hereby consent to receive massage treatment.

**Signature:** **Date:**

**First Name:** **Last Name:**

**Address:**

**Phone Number:**

**Mobile Number:**

**Email:**

**Date of Birth:**

**Occupation:**

HOW DID YOU HEAR OF CITYVIEW CHIROPRACTIC?

PATIENT REFERRAL: YES ☐ NO ☐ IF **YES**, PATIENT NAME

OTHER:

What is your primary complaint?

What is your general health status?

Is this due to a car accident? YES ☐ NO ☐ Do you have extended health care? YES ☐ NO ☐

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# HEALTH HISTORY

**Head/Neck:**
- ☐ Headaches
  Type:
- ☐ Vision problems
- ☐ Ear problems
- ☐ Hearing loss

**Skin:**
- ☐ Skin conditions
  Type:
- ☐ Bruise easily

**Women:**
- ☐ Menstrual problems
- ☐ Painful
- ☐ Heavy
- ☐ Scant

**Pregnant - Due Date**:

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

**Infections:**
- ☐ Hepatitis
- ☐ TB
- ☐ HIV, AIDS

**Muscles/Joints:**
- ☐ Rheumatoid arthritis
- ☐ Gout
- ☐ Other:

**Cardiovascular:**
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart Attack
- ☐ Stroke/CVA
- ☐ Pacemaker or similar device

**Injury:**
Date:

Current Symptoms:

| | Current Pain/ Stiffness | Previous Pain/ Stiffness |
|---|---|---|
| Neck | ☐ | ☐ |
| Low Back | ☐ | ☐ |
| Mid-Back | ☐ | ☐ |
| Upper Back | ☐ | ☐ |
| Shoulders | ☐ | ☐ |
| Leg: Left/Right | ☐ | ☐ |
| Knee: Left/Right | ☐ | ☐ |

Surgery:

Date:

Nature:

Current Medication:

Other Medical Conditions: (e.g. digestive conditions, gynecological conditions, hemophilia, etc.)

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***CITY VIEW CHIROPRACTIC SPORTS INJURY & THERAPUTIC EXERCISE CLINIC PRIVACY POLICY***

Privacy of Personal Information is an important principal to City View Chiropractic Clinic. We are commitment to collecting, using, and disclosing personal information responsibly and only to the extent necessary for the goods and services we provide. We also try to be open and transparent as to how we handle personal information. This document describes out privacy policies.

☐ I consent to City View Chiropractic Sports Injury & Therapeutic Exercise Clinic contacting my doctor regarding my referral for massage therapy. (This does not apply to patients without referral from their doctor.)

☐ Consent may be withdrawn at any time via phone or in person by contacting either the clinic or your therapist.
Initials

## CONSENT TO TREATMENT FORM

*In compliance with the Consent to Treatment Act, 1992 and Bill 109*

I, , of my own free will, provide my full, voluntary, informed consent to be treated at City View Chiropractic sports injury & therapeutic exercise clinic for:

☐ General Relaxation

☐ The following complaints:

Alternate course of action has been explained to me as well as the possible risks and side effects on my therapist's proposed treatment plea.

I understand the consequences of choosing/not choosing this treatment.

I understand that my consent may be revoked at any time at any time before or during the treatment if I choose to do so. I may also choose to alter or revise this treatment plan at any time before or during the treatment.

Patient's Signature: Date:

## CANCELLATION POLICY

I understand that 24 hours notice is required to change or cancel a massage therapy appointment, and in the event that I do not give 24 hours notice, I will be required to pay full fee for the missed appointment.

Patient's Signature Date: