

File #: _____

Date: _____

General Information

Last Name: _____ D.O.B. _____

First Name: _____

How do you wish to be addressed in our office? (First Name, Mr., Mrs., Dr., Nickname, Etc...)

Identify as? M F Other: _____ Sex at birth: M F

Address: _____

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

Home Phone: _____ Cell Phone: _____

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

How do you wish to be contacted by our office regarding your appointments?

Email Phone

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

Children: Y N Number: _____ Ages: _____

(Females) Are you pregnant? Y N How many weeks? _____ Estimated due date: _____

Family Dr. Name: _____ Phone: _____

Current / Previous Wellness Care? (check all that apply)

Chiropractic Physiotherapy Naturopathy Massage Therapy Osteopathy

Location: _____

How did you hear about us? (referral, ad, Google) _____

Reason for consulting the office:

I have a specific problem and require help only with this problem.

After my specific problem has been relieved, I am interested in strategies for maintenance.

After my specific problem has been resolved and I understand methods to ensure it does not return, I am interested in strategies to improve my general health.

I have no symptoms and I feel well. I am interested in strategies to help me to continue to feel well, or even better.

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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 & Wellness Group's privacy policy in full at any time.

Health History: (please check all that apply)

Musculoskeletal

- Bone or joint disorder
- Tendonitis
- Bursitis
- Fractures
- Rheumatoid Arthritis
- Osteoarthritis
- Strains / sprains
- Low back / hip / leg pain
- Neck / shoulder / arm pain
- Headaches / head injuries
- Migraines
- Jaw pain / TMJ syndrome
- Spasms / cramps
- Other: _____

Skin

- Allergies / skin irritations
- 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
- Chrone'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): _____

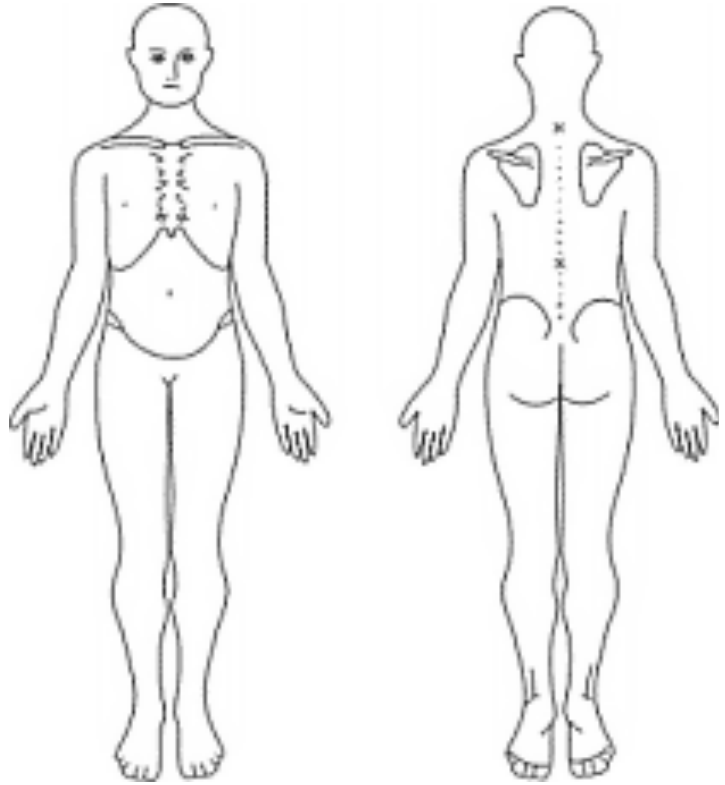
Injuries/Accidents still affecting daily activities (please list): _____

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

General Health Status (please check one): Poor Average Good Excellent

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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.

Cancellation Policy

While the clinic does provide regular appointment reminders, I acknowledge that I am responsible for my attendance and that 24 hours' notice is required should I wish to cancel or reschedule my appointment. If less than 24 hours' notice is given, or If I fail to show for my scheduled appointment, I understand that one of the following charges will be applied to my account:

- A cancellation fee of \$25.00 should I cancel an appointment with less than 24 hours' notice
- A full appointment fee should I not show for my scheduled appointment without notice

Please initial to confirm that you have read the cancellation policy and agree to pay any outstanding balances owing. _____ (Initial Here)

Name: _____

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

Parental/Guardian Signature: _____ Date: _____