Pacific

CHIROPRACTIC and MASSAGE THERAPY

1065 Cambie Street Vancouver BC V6B 5L7 (604) 687-2900

Wellness and Rehabilitation Services

RMT

NAME_____ DATE_____
ADDRESS_____ HOME NUMBER_____
POSTAL CODE_____ WORK NUMBER_____
WHO REFERRED YOU?_____ CELL/PAGER NUMBER_____
DATE OF BIRTH_____ CARECARD#_____
E-MAIL ADDRESS_____ What is the best way to contact you? Work/home/cell

YOUR APPOINTMENT: Your appointment time is reserved especially for you. If you find it necessary to reschedule an appointment, a minimum of 24 hours notice is required so we may allow others to utilize this time. Otherwise it will be necessary to charge you 60% of your scheduled appointment fee. Thank you for your cooperation and understanding.

SIGNATURE_____ **DATE**_____

Reason for appointment:_____
_____

PLEASE LIST AND DATE: Any diagnosed medical conditions:_____
_____

Accidents/Injuries/Illness_____
_____
Surgical Procedures:_____
_____
Do you take Medications? (Daily, weekly, monthly) Please list the medications and what they are for:_____
_____
List any ALLERGIES:_____
_____
Have you had a professional massage before?_____
Other health professional visits? Chiropractor_____ Naturopath____ Physiotherapist_____
Other_____
Please describe Occupation:_____ Continual posture?_____

Repetitive Movements (describe)?_____
How is your overall health (mental, emotional, and physical)?_____
_____
Have you had a major change in the last year? (If so, please describe)_____
_____
What is your major source of stress?_____
How would you describe: Your energy level?_____ Sleep pattern:_____
Diet?_____ Water intake(# of cups)_____

Do you use any of the following? **D**aily **O**ften **I**nfrequently **N**ever
Cigarettes:_____ Coffee:_____ Alcohol:_____ Carbonated Drinks:_____ Pain Meds:_____

Please mark X for conditions that apply now. P = Past F = Family History

Neck/Back Pain	Rib Pain	Aching Muscles/Joints
Limited Joint Movement	Artificial Joint/Steel Pin	Painful/Swollen Joints
Osteoarthritis	Rheumatoid Arthritis	Fractures
Kidney Disorders	Painful Menstruation	Pregnant (or possibility)
Menopause	Nausea/Vomiting	Problems swallowing
Abdominal Pains	Heartburn	Headaches
Migraines	Whiplash	Neck Tension
Ear Ache/Infection	Hearing Problems	Frequent Anxiety/Fear
Depression	Muscle Weakness	Paralysis
Numbness	Tingling	Epilepsy
Skin Infection	Skin Conditions	Emphysema
Asthma	Dizziness/Fainting	Shortness of Breath
Heart Disease/Conditions	Stroke	Edema (swelling)
Chest Pains	Low Blood Pressure	High Blood Pressure
Varicose Veins	Bruise Easily	Cold Hands/Feet

General

Aids/HIV	Cancer
Diabetes	Fibromyalgia
Multiple Sclerosis	

I am responsible for my health and I understand that all appointments I book at this clinic are especially reserved for me and that I am responsible for payment of all services rendered and all charges on my account.

SIGNATURE_____ **DATE**_____