Unique Family Chiropractic
4-201 Williamson Dr. W. Ajax, Ontario L1T 0J8

Brian Jones, RMT
Courtney Sarch, RMT
416-342-1932
www.uniquechiropractic.com

CONFIDENTIAL PATIENT INFORMATION

GENERAL INFORMATION:

Name: _____ Date: _____
Address: _____ Home Phone: _____
City, Province, Postal Code: _____ Work Phone: _____
Email Address: _____ Cell Phone: _____
Date of Birth: (D)_____ (M)_____ (Y)_____ Age: _____ Gender: Male □ Female □ OK to leave a voicemail: Yes / No
Occupation: _____ Family Physician: _____
How did you hear about us? Internet □ Facebook □ Doctor □ Friend / Family □ Live Nearby □ Coach □ Other: _____
Who may we thank for referring you? _____
Have you seen a Massage Therapist in the past? Yes □ No □ If yes, when? _____

HEALTH HISTORY:

What is the reason you are seeking massage therapy? _____
Did a health care practitioner refer you for massage therapy? Yes □ No □
Have you had surgeries? Yes □ No □ If yes, please list: _____
Women Only: Pregnant: Yes □ No □ If yes, _____ weeks/months Gynecological Issues Yes □ No □
Prescribed Medications (ie. Blood Pressure Pills): Yes □ No □ Please list: _____
Over-the-counter Medications (ie. Aspirin): Yes □ No □ Please list: _____
Vitamins/Supplements/Natural Products (ie. Muti-vitamin): Yes □ No □ Please list: _____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
- □ high blood pressure
- □ low blood pressure
- □ chronic congestive heart failure
- □ heart attack
- □ phlebitis/varicose veins
- □ stroke/ CVA
- □ pacemaker or similar device
- □ heart disease

Respiratory
- □ chronic cough
- □ shortness of breath
- □ bronchitis
- □ asthma
- □ emphysema

Is there a family history of any of the above?
Yes □ No □ Please list:
_____

Infections
- □ hepatitis
- □ skin conditions
- □ TB
- □ HIV
- □ Herpes

Other Conditions
- □ loss of sensation
- □ allergies/ hypersensitivity
- □ epilepsy
- □ cancer
- □ skin conditions
- □ arthritis

Is there a family history of any of the above?
Yes □ No □ Please list:
_____

Do you have any internal pins, wires, artificial joints or equipment?
Yes □ No □

Head/Neck
- □ history of headaches
- □ history of migraines
- □ vision problems
- □ vision loss
- □ ear problems
- □ hearing loss

Is there a family history of any of the above?
Yes □ No □ Please list:
_____

Do you have any medical conditions? Ie: osteoporosis, mental illness, haemophilia or digestive conditions) ?
Yes □ No □ Please list:
_____
_____

Updated: (not to be completed on initial day)

Date:	**Client's Initials:**	**RMT's Initials:**
Date:	**Client's Initials:**	**RMT's Initials:**
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Date:	**Client's Initials:**	**RMT's Initials:**

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LIFETIME STRESS PROFILE:

Did you:	**as a:**	**Child**	**Teenager**	**Adult**	**None**
Play contact sports		☐	☐	☐	☐
Have any serious falls or traumas		☐	☐	☐	☐
Get involved in any car accidents		☐	☐	☐	☐
Use medication for extended periods		☐	☐	☐	☐
Have any work injuries			☐	☐	☐
Used street drugs for extended periods			☐	☐	☐
Drink alcohol			☐	☐	☐
Smoke cigarettes			☐	☐	☐

On a scale from 1 – 10 describe your **stress level** (1 – None / 10 – extreme)

Personal: _____

Occupational: _____

LIFESTYLE QUESTIONAIRE:

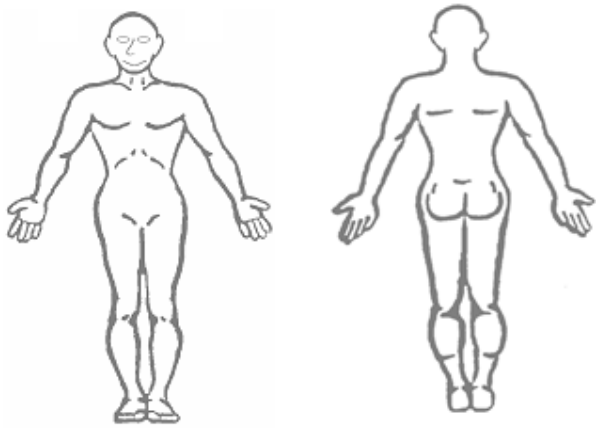
How would you rate your overall health	Poor	Good	Excellent
How would you rate your overall stress level	Low	Medium	High
How would you rate your commitment to improve your health	Low	Medium	High
How would you rate your daily water intake	Poor	Good	Excellent
How would you rate your level of exercise	Low	Medium	High
How would you rate your quality and quantity of sleep	Poor	Good	Excellent

PAIN DIAGRAM:

If you are experiencing any pain or discomfort, please identify these areas by drawing on the diagrams below. You may use the symbols listed to help describe how you feel. Mark all your areas of discomfort.

SYMBOLS:

Stiff & Tight	++++
Dull & Aching	xxxx
Sharp & Stabbing	///////
Burning	====
Pins & Needles	••••••
Numbness/loss of sensation	^^^^^



We invite you to discuss with us any questions regarding our care. The best health services are based on a friendly, mutual understanding between you and the massage therapist.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made.
By signing below – I acknowledge all information is true:

Print Patient Name: _____ Date: _____

Signature: _____