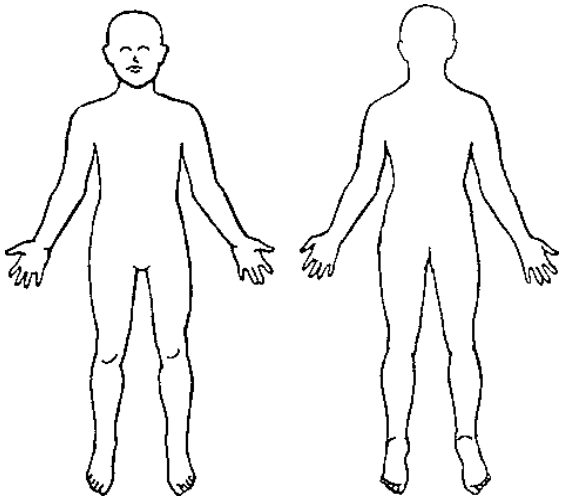
COUNTRY CHIROPRACTIC

Remedial Massage
PATIENT INTAKE INFORMATION **Date:** ___/___/___

NAME:	**SEX: M | F**	**DOB:**	**AGE:**
Address:			**Postcode:**
Phone (Home):	**Phone (Work):**	**Mobile:**	
Email:			
Marital Status:	**Spouses Name:**		
Children (List + Ages):			
OCCUPATION:	**EMPLOYER:**		
How did you find our clinic? Person:	Website Signage Facebook Other:		

WHAT IS YOUR MAJOR HEALTH CONCERN?

Please indicate & circle where your present symptoms are on the diagram below using the symbols in the below



Aching Pain: A
Burning Pain: B
Stabbing Pain: S
Numbness/Pins/Needles: P

Indicate the intensity of your pain below (circle):

NO PAIN **0 1 2 3 4 5 6 7 8 9 10** WORST PAIN

Main Concern:

When did it start?

Have you had it before? **Y** **N**

Is it (circle): getting worse constant comes/goes getting better

What caused it / How did it happen?

Is the pain referring to other areas of your body?

What makes it better?

What makes it worse?

What treatment have you had? (circle) GP Chiro Physio Other:

How have these problems interfered with your activities?

Sporting ability / Fitness / Work ability?

Sleeping Posture: (circle) Side Back Stomach

Sports you play or used to play:

OTHER PROBLEMS: (please tick and elaborate if necessary)

- ☐ Neck pain
- ☐ Mid-back pain
- ☐ Low back pain
- ☐ Other joint pain:
- ☐ Numbness or Tingling
- ☐ Scoliosis
- ☐ Spinal Surgery
- ☐ Osteoarthritis / Osteoporosis
- ☐ Rheumatoid / Psoriasis
- ☐ Cancer / Malignancy
- ☐ Stroke
- ☐ Asthma or Breathing Difficulty
- ☐ Lung or Chest problems
- ☐ Abdominal pain
- ☐ Digestive issues
- ☐ Kidney, bladder issues
- ☐ Reproductive issues
- ☐ Heart or circulatory issues
- ☐ Blood pressure issues
- ☐ Headache or Migraine
- ☐ Dizziness or Vertigo
- ☐ Epilepsy
- ☐ Sinusitis or Hay Fever
- ☐ Eyes, ears, nose, throat issues
- ☐ Skin issues
- ☐ Allergies
- ☐ Weight issues
- ☐ Anxiety/Depression
- ☐ Fatigued/Difficulty Sleeping
- ☐ Varicose Veins

GENERAL HEALTH: (please answer to the best of your ability)

Current Health Care Practitioners: (who, and what for?)

List Vitamins/Supplements:

List Current Medications:

List all injuries:

Major Illnesses during lifetime:

Detail any motor vehicle accidents / other injuries:

List surgeries or hospital stays:

List previous x-rays, CT scans, MRI's:

Do you currently smoke? (circle) **Y** **N** How many? (per day) Did you Previously?

Do you drink alcohol? (circle) **Y** **N** Total per day? (Std Drinks)

Do you wear shoe inserts? (circle) **Y** **N** Details:

Do you wear a dental splint? (circle) **Y** **N** Details:

What is your current stress level? (circle) No Stress **1 2 3 4 5 6 7 8 9 10** High Stress

(Females) Do you use a contraceptive pill? (circle) **Y** **N**

Apart from usual medical details, it is important that you answer these questions:

Are you a diabetic?:	**Y**	**N**
Have you ever experienced a fit, faint or funny turn?:	**Y**	**N**
Have you been fitted with a pacemaker or any other electrical implants?:	**Y**	**N**
Do you have a bleeding disorder?:	**Y**	**N**
Are you taking anticoagulants or other medication?:	**Y**	**N**
Do you have damaged heart valves or have any other particular infection risk?	**Y**	**N**
Are you pregnant or actively trying for a pregnancy?:	**Y**	**N**
Do you suffer from medical allergies?:	**Y**	**N**

Anything else you would like us to know?

MISSED APPOINTMENT & PRIVACY POLICIES

I am aware of the Missed Appointment Policy and associated fees.
I consent to the collection of my personal information as outlined in the Privacy Policy.

Patient's Signature:_____Date: _____

INFORMED CONSENT TO TREATMENT

Please refer to our informed consent document and appropriate discussions with your practitioner.

Patient's Signature: _____

Date:_____

Massage Therapist's Signature :_____

Date : _____