Foster Family Chiropractic & Associates - Laura Armstrong RMT & Amber Johnston RMT

Dear Patient: Please complete the information requested below as accurately as possible in order to assist your therapist in treating you safely. Feel free to ask any questions about the information being requested. All information provided below will be kept confidential unless allowed or required by law. Your written permission will be required to release any information. Any changes in your health status should be provided to your therapist so that treatment modifications may be made, as needed. **Please complete all pages of this form.**

PERSONAL HISTORY

initial Visit Date: _____

Name:_____ Address: _____

City: _____ Province:_____ Postal Code: _____

Home Phone: _____ Birth date: _____ Age:_____Sex: ☐ M ☐ F

Business Phone: _____ Cell Phone: _____

E-Mail Address: _____

Type of Work _____ Business/Employer: _____

Emergency Contact: _____Phone Number: _____ Relationship: _____

Family Physician (Name / Address / Tel. No.) _____

Who may we thank for referring you to this office? _____

CURRENT HEALTH CONDITION

1. What is your main reason for seeking treatment today? _____

When did this condition begin? _____ Has the condition occurred before? ☐ Yes ☐ No

Is the condition: Job-related Home Injury Fall Other: _____

If auto accident related, please note Accident Date / Details: _____

2. What aggravates your condition? ☐Sitting ☐Standing ☐Bending ☐Lifting ☐walking ☐Lying Down ☐Cold ☐Dampness ☐Other:_____

What relieves your condition? ☐Bed Rest ☐Ice ☐Heat ☐Massage ☐Medication ☐Other _____

Is it getting: ☐ Worse ☐Constant ☐Comes/Goes ☐Better

Character of Pain: ☐Sharp ☐Dull ☐Ache ☐Pins & Needles ☐Numb ☐Burning ☐Radiating ☐Throbbing ☐Constant ☐Other

3. Please circle (○) one of the numbers below to indicate the severity of your pain.

LEAST 1 2 3 4 5 6 7 8 9 10 *WORST*

4. Are you currently seeing a health professional for this condition ☐ Yes ☐ No ☐ any other condition?
   Type of treatment? ☐ MD ☐ Chiropractor ☐ Physiotherapist ☐ Psychotherapist / Counselor ☐ Other
5. Medication, please list all medications you currently take:_____
6. Any other conditions not listed _____

PAST HEALTH HISTORY

1. Have you had any: Fractures / Strains / Sprains / Bursitis / Dislocations? ☐Yes ☐ No
2. Do you have any: Internal pins, wires / artificial joints or special equipment? Where: _____
3. Major Surgery/Operations: ☐Appendectomy ☐Tonsillectomy ☐Gall Bladder ☐Hernia ☐Back ☐Surgery ☐Heart
   Other:_____
4. Have you ever had: ☐Childhood Traumas ☐ Sports Injuries ☐ Motor Vehicle Accidents ☐ Work Injuries
5. Hospitalization (other than above surgery): _____ _____

6. Please CHECK (✓) any of the following you have now or CIRCLE (O) any experienced in the past year:

General
- ☐ Fatigue
- ☐ Allergies / Sensitivities
- ☐ Dizziness / Fainting
- ☐ Fever
- ☐ Headaches
- ☐ Forgetfulness / Confusion

Musculo-Skeletal
- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness
- ☐ Joint Pain/Stiffness
- ☐ Arthritis (Osteo or R.A)
- ☐ Osteoporosis

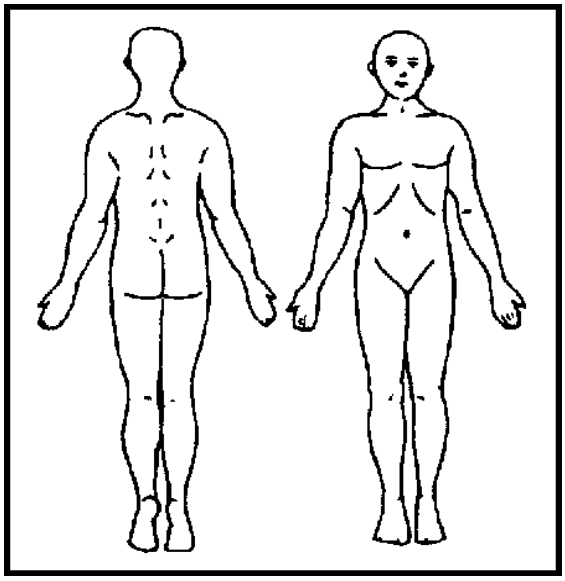
Heart and Lungs
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Lung problems/congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

Nervous System
- ☐ Stress / Anxiety
- ☐ Numbness / Tingling
- ☐ Paralysis
- ☐ Spinal Cord Injury
- ☐ Parkinson's
- ☐ Seizures / Epilepsy
- ☐ Multiple Sclerosis
- ☐ Poliomyelitis / Polio

Skin Conditions
- ☐ Athlete's Foot / Warts
- ☐ Rashes / Eruptions
- ☐ Eczema / Psoriasis
  Allergies / Infectious conditions

Stress Levels
- ☐ High
- ☐ Moderate
- ☐ Very Little

Please outline the area of your discomfort and any radiation of pain on this diagram.



CONCENT TO TREATMENT

I _____ understand massage therapy involves manipulation of soft tissue and joints. As with any manual therapy, there are potential risks or side effects to treatment, such as delayed muscle soreness, headaches, or destabilization of medications and blood clots.

It is my responsibility to inform my massage therapist of any changes in my medications and/or health history, as they arise, to ensure my safety.

Removal of clothing is optional; however, it is preferable that clothing be removed in order for my Massage Therapist to most effectively provide treatment. Only the areas being massaged/treated will be uncovered. My therapist will obtain my verbal consent to massage these areas prior to treatment, or during the treatment if necessary.

It is my right to refuse, modify, or terminate treatment at any time. Communication with my therapist is important to ensure the most safe and effective treatment.

Massage therapists do not diagnose illness or disease and, therefore, massage therapy is not a substitute for a full medical examination or diagnosis.

Signature: _____ **Date:** _____