Valentino Chiropractic Clinic
332 Browns Line
Etobicoke, ON. M8W 3T6
Tel: 416-259-4911 Fax: 416-259-1824

MASSAGE THERAPY PATIENT INFORMATION

First Name _____ **Birth Date: DD/MM/YY**_____ **Age** ____

Address _____ **City** _____ **Province** _____ **Postal Code** _____

Home Phone _____ **Work Phone** _____**ext**_____ **Cell Phone** _____

E-Mail Address: _____

What is your **primary** complaint? _____
Aggravating Factors:_____
Do you exercise/play sports?_____

Other complaints? _____

Have you consulted with other doctor's for your present condition(s)? _____If yes, whom? _____
Name of Family Doctor: _____ When was your last Physical Examination? _____

Do you or your spouse have Extended Health Care Insurance? ☐Yes ☐ No
Name of Insurance Co._____

How were your referred? ☐Patient ☐Drive By ☐Sign ☐Website ☐internet search ☐other:
_____

Is your problem related to an injury? ___Yes ___No
Is your problem related to a: ___Car Accident ___ Slip/Fall ___ Work related ___ other

In Case of Emergency contact: _____ Phone # _____

Have you had previous Massage Therapy? ___Yes ___No For what condition? _____
Date of Last Massage: _____

Are you **currently** involved in any other form of **rehabilitation/therapy or healthcare**? _____

Please list any **medications** you are **currently** taking:_____

Do you have any Pins/Plates/Pacemakers/Joint replacements? If yes, Where?_____

Are you pregnant? IF so how far along?_____ Due Date_____ Any difficulties?_____

Please list any surgeries you have had _____

Health History (Please circle any that apply to you)

Head/Neck:
Headaches/Migraines
Vision problems/Contact lenses
Allergies: _____
Epilepsy/Seizures
Hearing Aids
Earaches/ Sinus problems
Neck Pain
Dizziness

Cardiovascular:
High blood pressure
Low blood pressure
Poor circulation
Heart disease/Heart Attack
Fainting
Stroke
Varicose Veins

Digestive:
Poor appetite
Constipation
Diarrhea
Liver/gallbladder
Ulcers
Kidney/bladder
Digestion
Hernia
Indigestion/heart burn
Crones/colitis/IBS
Diabetes

Respiratory:
Chronic cough
Asthma
Shortness of breath
Bronchitis
Emphysema
Smoker
Freq. colds

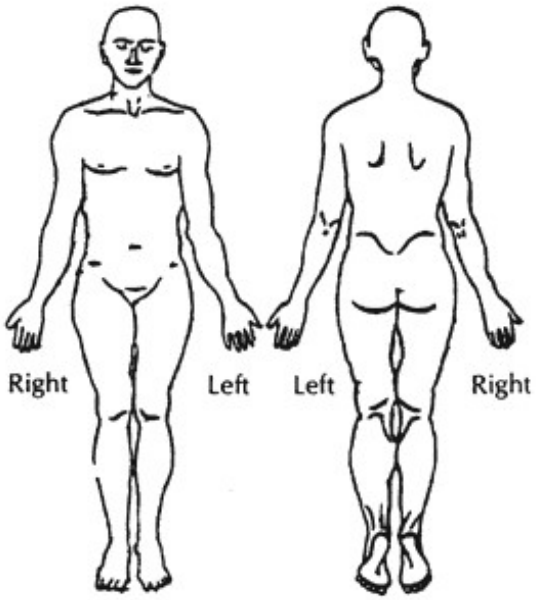
Men:
Prostate issues

Women:
Menstrual difficulties
Menopausal

Other:
Hepatitis
Cancer _____
Tuberculosis
HIV+
Bruise Easily/Rashes
Skin Disease/ Eczema

Muscle and Joints:
Neck Pain
Mid back Pain
Lower back Pain
Leg Pain R or L
Arm Pain R or L
Shoulder Pain R or L
Knee Pain R or L
Elbow or Wrist Pain R or L
Numbness or Tingling
Stiffness
Arthritis/Degerative Disease
Osteoporosis
Fibromyalgia
Other _____

Place X's on the area that you have *pain or discomfort* on the picture below:



Consent to Treatment

Massage Therapy is the manipulation of soft tissues of the body to gain a therapeutic response. Soft tissues include: muscles, skin, tendons, ligaments and membranes. The confidential information provided by you is required to assist us in forming an assessment and treatment plan, which will be explained to you before treatment. This will help you to understand the processes behind your plan and how we can work together to alleviate it. If any new condition or concurrent treatment arises, please let your therapist know so that we may provide you with the best suited care. You may stop treatment at any time and feel free to ask your therapist any questions you might have.

Please sign below to confirm that you have read and understand the above, as well as a CONSENT to treatment.

Date_____ **Signature**_____

CANCELLATION POLICY:

We require 24 hours' notice to cancel or reschedule your appointment.

If you are unable to provide this notice, we will charge you the FULL fee for the missed appointment if we are unable to fill the appointment time. If you have an emergency, please let us know so that we can treat your specific situation with personal attention. We do not consider conflicts to be emergencies. This cancellation policy is necessary for our small business to continue to serve our clients in need of treatment, and also to make massage therapy a feasible career for our therapists. The Massage Therapists practice a maximum of 4-7 hours per day so that you can be sure to get high quality treatment and so that they can stay healthy and injury free. One missed appointment has a significant financial impact. Please call the clinic to cancel an appointment. E-mail cancellations will not be accepted. Thank you for your understanding. Please sign below to indicate that you have read and understand our cancellation policy.

Date_____ **Signature**_____