ATLAS CHIROPRACTIC & MASSAGE THERAPY

Dr. Karlo Pavich B.Sc., D.C.

Massage Therapy – Confidential Information

Date: _____ General Health Status:_____
Name: _____ Date Of Birth:_____
Address:_____ Family Physician:_____
City: _____ Province.:_____ Phone Number:_____
Postal Code: _____ Emergency Contact:_____
Phone: (H)_____ (C)_____ Phone: (H)_____ (C)_____
Occupation:_____ Referred by:_____

□ Male □ Female Are you, or could you be pregnant? □ No □ Yes

Are you currently taking any medications? (includes aspirin, ibuprofen, etc.) □ No □ Yes
If yes, please list medication and condition: _____

Are you currently taking any supplements?: (homeopathic, herbal, etc.) □ No □ Yes
If yes, please list supplement and condition: _____

Please list any allergies causing anaphylaxis or skin irritations: _____

Do you have any internal pins, wires, artificial joints, pacemaker, or other special equipment?: □ No □ Yes
If yes, Date: _____ Reason: _____

Have you ever been in a Motor Vehicle Accident, sustained Trauma, Athletic Injury, etc?:
□ No □ Yes If yes, please explain and state estimated date of occurrence.
Date: _____ Occurrence: _____

Have you ever been diagnosed with or have you ever experienced any of the following?
Please check the appropriate box.
If you have a family history of any of the following please specify by marking an F.

Cardiovascular and Respiratory

□ high / low blood pressure _____/_____ □ history of myocardial infarction
□ chronic congestive heart failure □ history of cerebro-vascular accident
□ heart disease □ phlebitis, varicose veins, etc.
□ hemophilia □ circulatory problems (Raynaud's, etc)
□ chronic cough □ bronchitis
□ emphysema □ shortness of breath
□ asthma □ difficulty breathing
Other:_____

Skin

□ infectious / contagious skin conditions □ irritated skin conditions
□ lack / loss of sensation or numbness □ hypersensitivity
Other:_____

Nervous and Musculoskeletal

□ epilepsy □ Multiple Sclerosis □ Parkinson's
□ arthritis □ bone or joint disease □ joint instability
□ tendonitis □ fractured bones □ jaw pain (TMJ)
□ Other:_____

General

□ hearing impairment □ vision impairment □ cancer / tumors
□ undiagnosed lumps □ diabetes □ kidney problems
□ liver problems □ digestive conditions □ eating disorder
□ gynecological conditions □ recent vaginal birth / abortion
□ drug / alcohol addiction / withdrawal □ infectious conditions (HIV, hepatitis, tuberculosis, etc.)
□ Other:_____

Have you ever been treated by a massage therapist before?: □ No □ Yes

What is the purpose of your visit or primary complaint?: _____

Are you currently being treated by any other health care practitioner(s)?: □ No □ Yes
If yes, please explain: _____
If yes, after verbal informed consent with yourself and the RMT, do you give permission for the R.M.T. to consult with other health care practitioner(s)?: □ No □ Yes

Do you know what started your **current** condition?: □ No □ Yes
If yes, please explain: _____

Are you, or have you ever been treated for this condition before?: □ No □ Yes
If yes, type of therapy and when: _____

What aggravates the condition?:_____

What relieves the condition?: _____

AFTER meeting with the Massage Therapist, please print and sign below.

I _____, confirm that all the above information is true and understand that if there is any change in my health status it is my responsibility to inform my massage therapist.
I understand that I may withdrawal my consent for all of the treatments or components of the treatments at any time, and that the treatment will end immediately or be modified accordingly.
I understand that all information in this form and all information provided to the massage therapist is strictly confidential and may only be released with my, the clients', consent.
The massage therapist has answered any questions I had.
I therefore give my consent to begin the proposed treatment plan.

Client Signature: _____ Date: _____

Signature of Parent / Guardian (if applicable): _____

Revision Dates (clients' initials needed) are below