Eaglewood Chiropractic Health Centre

105 Dartmouth Road
Bedford, NS, Canada, B4A 2L8
Tel: (902) 422 - 6688 Fax: (902) 860 - 6688

Who may we thank for referring you?: _____

Name: _____ Date: _____

Mailing Address: _____

Home Tel: _____ Work Tel: _____ Cell: _____

Email: _____ Health Card #: _____

Birthday: _____ Gender: _____ Marital Status: _____

Occupation: _____ # Children (Ages): _____

Alternate Contact: _____ Tel: _____

Family Doctor: _____ Tel: _____

Had a professional massage before? If so, when?: _____

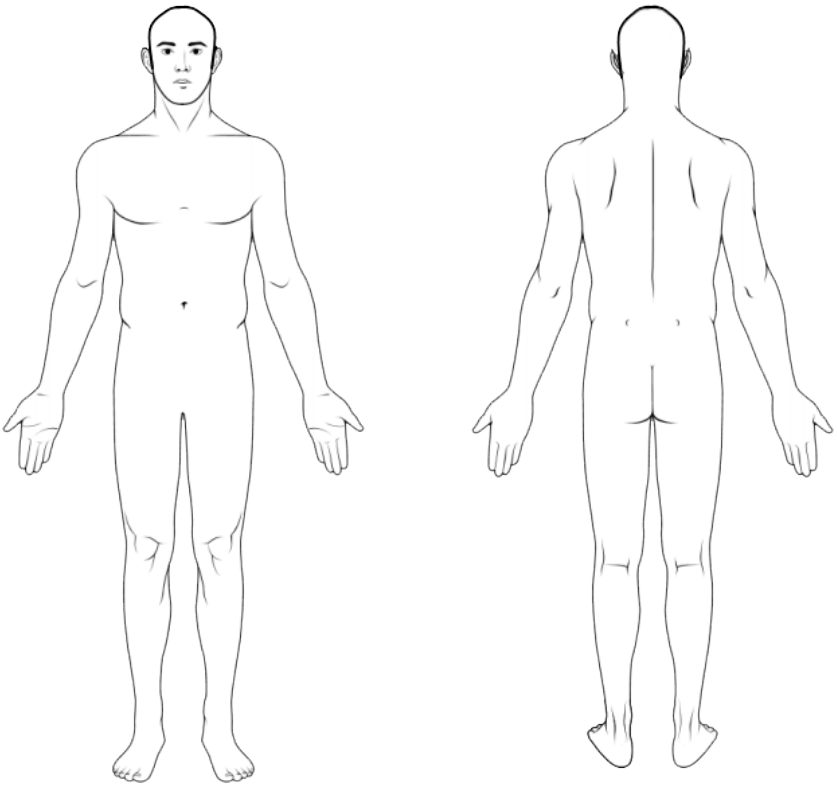
Seen other healthcare practitioners? If so, when?: _____

Allergies/Hypersensitivities: _____

List of Medications, Medical Conditions, Previous Injuries and Surgeries

Please tell us how we can help you

Please mark areas of complaint below



Health History and Entrance Form (Please check all that apply to you)

List of family history conditions: _____

General Symptoms
- ☐ Fainting/Dizziness
- ☐ Difficulty Sleeping / Fatigue
- ☐ Stress
- ☐ Headaches / Migraines
- ☐ Nervousness
- ☐ Numbness / Tingling; Where: _____
- ☐ Paralysis

Do You Have / Had?
- ☐ Diabetes; Onset: _____
- ☐ Epilepsy
- ☐ Neuromuscular Conditions
- ☐ Hypo / Hyper Glycaemic
- ☐ Depression
- ☐ Multiple Sclerosis
- ☐ Cancer; Where: _____
- ☐ Thyroid Problems
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Mental Illness
- ☐ Artificial Implants / Pins / Plates; Where:

_____

Male / Female
- ☐ Prostate Problems
- ☐ Pregnant; Due Date: _____
- ☐ Menstrual Cramping
- ☐ Menstrual Irregularity
- ☐ Birth Control
- ☐ Vaginal Pain / Infections
- ☐ Breast Pain / Lumps
- ☐ Menopausal

Lifestyle (Check all that apply)

Regular Exercise	☐ Yes	☐ No	☐ Mostly
Drink Plenty of Water	☐ Yes	☐ No	☐ Mostly
8 Hours of Sleep / night	☐ Yes	☐ No	☐ Mostly
Good Eating Habits	☐ Yes	☐ No	☐ Mostly

What is your general health?

_____

EENT
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Hearing Aid
- ☐ Stuffed Nose / Sinus
- ☐ Swollen Glands

Respiratory
- ☐ Chronic Cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Emphysema

Skin
- ☐ Rashes
- ☐ Excessive Dryness
- ☐ Acne
- ☐ Psoriasis
- ☐ Eczema
- ☐ Skin Cancer
- ☐ Bruise Easily

Joint / Muscle Discomfort
- ☐ Jaw
- ☐ Neck
- ☐ Shoulders
- ☐ Arms
- ☐ Hands
- ☐ Upper Back
- ☐ Mid Back
- ☐ Low Back
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet
- ☐ Bursitis
- ☐ Arthritis
- ☐ Family History of Arthritis

Cardiovascular
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Attack / Disease
- ☐ Congestive Heart Failure
- ☐ Stroke / Aneurysm
- ☐ Heart Murmur
- ☐ Pacemaker
- ☐ High Cholesterol
- ☐ Swelling of Ankles
- ☐ Cold Hands / Feet
- ☐ Poor Circulation
- ☐ Varicose Veins / Phlebitis

Gastrointestinal
- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Gas / Bloating
- ☐ Colitis
- ☐ Crohn's
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea / Vomiting
- ☐ Ulcer
- ☐ Abdominal Cramps
- ☐ Gallbladder Problems
- ☐ Liver Problems

Infections
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ HIV / AIDS
- ☐ Herpes
- ☐ Athlete's Foot
- ☐ Warts

Notes

_____

_____

_____

_____

CONSENT FORM FOR MASSAGE, MASSAGE THERAPY OR INTEGRATED THERAPY

It is your right to agree to what is done to your body during treatment. You exercise this right by giving your written consent. You may revoke your consent at any time. Please read the following information before signing this form. If you have any questions please do not hesitate to ask them.

I,_____, hereby request and consent to the performance of a massage, massage therapy or integrated therapy treatment and other massage.

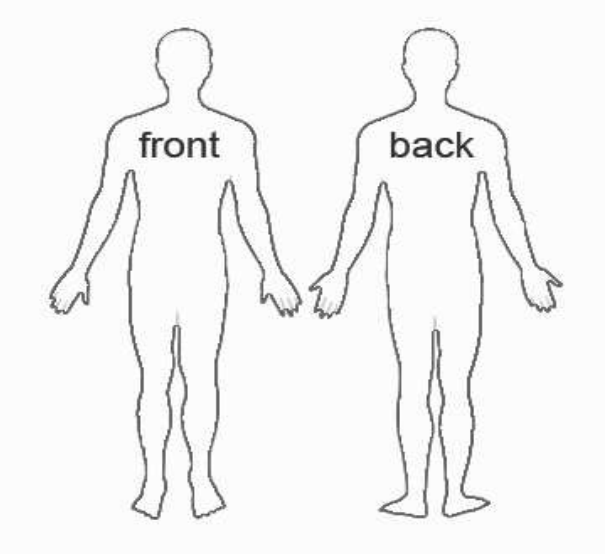
I have had an opportunity to discuss and ask questions regarding the nature and purpose of massage, massage therapy, or integrated therapy treatment. I understand that massage therapists do not diagnose illnesses or prescribe medications. I understand the benefits and the risks involved in receiving these treatments and that results are not guaranteed.

I fully understand that massage therapists may not anticipate all the risks and complications that might present themselves during my treatment and I wish to rely on them to exercise judgment during the course of the treatment which they feel is in my best interests. I will inform my massage therapist of any discomfort I feel during the therapy session and understand that the therapy will be adjusted to accommodate this.

I also understand that, as part of my ongoing care, I may receive communications from the clinic electronically or otherwise about my treatment and related services.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment, hereby confirming that I have read and understand the above consent and am capable of giving my full, voluntary informed consent to treatment.

I have indicated the areas I do not want massaged by circling the figures below.



_____
Name (Please Print)

_____
Signature of patient (or legal guardian)

_____ Date: _____
Signature of practitioner