CompleteCare CHIROPRACTIC

MASSAGE THERAPY INTAKE

Date: _____

Welcome,

We can't explain how excited we are that you're taking the first steps towards a healthier you. At Complete Care Chiropractic, we pride ourselves on customer service and quality care so that we can provide our patients with the best possible experience. At Complete Care Chiropractic, we offer a "no-pressure" environment, meaning we never pressure you into long-term contracts, instead we work with you in achieving your health goals. It's truly about you. We wish to extend you a warm welcome to Complete Care Chiropractic.

To get started, we need to get some details from you. We will start with a few basic questions outlined below. We will then get you to complete our intake form. Some questions may seem relevant, while others may seem unrelated. It is very important that you answer all of the questions completely and accurately.

Personal Details

Name: _____ Birthday: _____ / _____ / _____ Gender _____

Home Address: _____ City: _____ Postal Code: _____

Telephone (Home)_____ (Work)_____ (Mobile)_____

E-mail address:_____

Emergency Contact:_____ Relationship: _____ Phone: _____

Occupation: _____ Employer: _____

Medical Doctor: _____ Approximate last visit date: _____

How would you like to receive appointment reminders? ☐Text Reminders ☐Email ☐Home Phone ☐Work Phone

How did you hear of this practice? _____

PRIMARY COMPLAINT

Please indicate your primary complaint (ONLY PICK 1).

☐ Jaw Pain	☐ Low Back Pain	☐ Hand Pain	☐ Ankle Pain
☐ Headache	☐ Shoulder Pain	☐ Hip Pain	☐ Foot Pain
☐ Neck Pain	☐ Elbow Pain	☐ Thigh Pain	☐ Other: _____
☐ Mid Back Pain	☐ Forearm Pain	☐ Knee Pain	
☐ Rib Pain	☐ Wrist Pain	☐ Lower Leg/Shin pain	

Please answer the following questions regarding your primary complaint.

What side of the body is your pain on?	Left Side Right Side Both Sides Middle
When did it start? (exact as possible)	_____
What do you think caused it?	_____
How severe is the pain?	(min) 0 1 2 3 4 5 6 7 8 9 10 (max)
How often do you experience the pain?	< 25% of the time 25-50% 50-75% >75% of the time
Since the pain started, has it changed?	Getting Better Staying the Same Getting Worse
When is the pain at its worst?	Morning Afternoon Evening Nighttime No Difference
What makes the pain better?	Heat Ice Rest Movement Sitting Standing Walking Medications
What makes the pain worse?	Lifting Bending Coughing Sneezing Sitting Standing Walking Movement Rest
What does the pain feel like?	Sharp Stabing Dull Ache Throb Burning Numb Tingling Pins/Needles Other: _____
Does the pain refer to other areas?	Jaw Forehead Back of head Neck Mid Back Ribs Low Back Shoulder Elbow Forearm Wrist Hand Hip Thigh Knee Lower Leg Ankle Foot
Have you tried anything to help resolve it?	Chiropractic Physiotherapy Massage Family Doc Acupuncture Other: _____
Have you had this pain before?	☐ Yes ☐ No If yes, what helped the pain then? _____ If yes, does the pain feel similar? _____

MEDICAL HISTORY

1. Please list all current medications (including vitamins etc): _____

_____

2. Have you ever had any major car/work/sports accidents, broken bones, dislocations or any other injuries? _____

_____

3. Have you ever had any surgeries/hospitalizations? _____

_____

4. In the past 5 years, have you had any diagnostic tests (X-ray, MRI, CT, blood test, ultrasound etc): _____

_____

5. Have you ever experienced any of the following medical illnesses?

☐ HIV	☐ Hepatitis	☐ Stroke	☐ Heart Attack	☐ Hypertension	☐ Varicose Veins
☐ DVT	☐ Pacemaker	☐ Rheumatic Fever	☐ Pneumothorax	☐ Asthma	☐ Chronic Bronchitis
☐ COPD	☐ Emphysema	☐ Tuberculosis	☐ Epilepsy	☐ MS	☐ Depression
☐ Anxiety	☐ Polio	☐ Syphilis	☐ Meningitis	☐ Parkinson's	☐ Arthritis
☐ Cancer	☐ Osteoporosis	☐ Kidney Stones	☐ UTI	☐ Hemorrhoids	☐ Thyroid Disease
☐ Diabetes	☐ Anemia	☐ Allergies: _____		☐ Other condition: _____	

FAMILY HISTORY

7. Does anyone else in the family suffer from this condition: _____

6. Are you aware of any conditions/diseases/illnesses that run in the family: _____

SYSTEMS REVIEW

Are you currently experiencing any of the following?

General
- ☐ New mole
- ☐ Change in Mole
- ☐ Rashes
- ☐ Discolorations
- ☐ Bleeding
- ☐ Bruising
- ☐ Fatigue
- ☐ Muscle Aches
- ☐ Joint Pain
- ☐ Weakness
- ☐ Numbness
- ☐ Leg Cramps
- ☐ Leg Swelling

Gastrointestinal
- ☐ Heart Burn
- ☐ Bloating
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Aggr. by food
- ☐ Aggr. by drinks

ENDO
- ☐ Excessive Thirst
- ☐ Altered Appetite
- ☐ Temp Intolerance

EENT
- ☐ Ringing in Ears
- ☐ Ear Pain
- ☐ Balance Issues
- ☐ Jaw Issues
- ☐ Sore throat
- ☐ Glasses/contacts

CSV/RESP
- ☐ Palpitation
- ☐ Cough
- ☐ Chest Pain
- ☐ Difficulty Breathing

NVS
- ☐ Mood changes
- ☐ Memory Loss
- ☐ Seizures
- ☐ Sleep Issues
- ☐ Tremors/Shakes
- ☐ Nervousness

URINARY
- ☐ Painful Urination
- ☐ Burning
- ☐ Discoloration
- ☐ Blood in Urine
- ☐ Incontinence

FEMALE ONLY
- ☐ Breast Lump
- ☐ Mid Cycle Bleed
- ☐ Irregular Periods
- ☐ Vaginal Discharge
- ☐ Vaginal Bleeding
- ☐ Pregnant
- ☐ Birth Control
- ☐ Hormone Therapy

MALE ONLY
- ☐ Bleeding
- ☐ Scrotal lump
- ☐ Scrotal swelling

RED FLAGS

Are you currently experiencing any of the following?

☐ Recent Infection	☐ Fever / Chills	☐ IV Drug Use	☐ Steroid Use	☐ Alcohol Use
☐ Osteoporosis	☐ Cancer	☐ Previous Cancer	☐ Weight Loss	☐ Night Pain
☐ Night Sweats	☐ Blood In Stools	☐ Altered Bowel Habits	☐ Altered Urination	☐ Recent Dizziness
☐ Recent Fainting	☐ Trouble Talking	☐ Trouble Swallowing	☐ Double Vision	☐ Numbness
☐ New Headache	☐ Altered Headache	☐ Vision changes	☐ Hearing changes	☐ change in taste
☐ Change in smell	☐ Cognitive changes	☐ Severe Headache that peaks in Seconds		☐ Abdominal Pain
☐ Heartbeat Sensation in Stomach		☐ Other: _____		

Intake Form Acknowledgement

I acknowledge and confirm that the above information is correct and true. I also provide my consent to allow the health practitioner to perform the exams/tests that he/she deems clinically relevant to come to a clinical impression and/or plan of management. **To be signed after consultation.

Sign:_____ (Patient/Guardian) Date: _____

Informed Consent To Massage Therapy

I understand that the Registered Massage Therapist at Complete Care Chiropractic is providing massage therapy services within their scope of practice as defined by the College of Massage Therapist of Ontario (CMTO). The therapist has discussed the proposed assessments/examinations, the relevant findings as well as the proposed plan of management.

I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment, however the expected benefits have been discussed. I acknowledge that with any treatment there can be risks including but not limited to sprains, strains, bruising, lighted headed or dizziness, and tenderness. The potential risks and/or side effects have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form, as provided by my therapist, and disclosed to the therapist all medical conditions affecting me. It is my responsibility to keep the therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge. I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination.

I have read the above noted consent and I have had the opportunity to ask questions about its contents and my therapy. By signing this form I voluntarily confirm my consent to proceed with a health assessment/reassessment and massage treatment by the massage therapist. I also understand that I can withdraw or alter my consent at any time and assessment and/or treatment will be stopped. This consent shall also serve beyond the initial treatment plan until consent is either withdrawn or new medical information is revealed that may alter the risks or treatment options.

I have requested a health assessment/reassessment and/or treatment that involves in whole or in part, the following sensitive areas indicated below (tick the relevant boxes):

☐ Buttocks (Gluteal muscles)

☐ Upper Inner Thigh

☐ Chest Wall Muscles

☐ Breast (s)

Date: _____ / _____ / _____

Print:_____ (Patient/Guardian) Sign:_____ (Patient/Guardian)

Print:_____ (Practitioner) Sign:_____ (Practitioner)

Office Policy

Here at the Complete Care we have developed a set of office policies to ensure that all of our patients receive the quality care that they deserve. Out of respect towards our staff and other patients, we ask that you do your best to follow these policies.

Accuracy of Information

I acknowledge and confirm that all the information provided by myself, to the clinic is in fact correct and true. This includes all the information contained within all forms of communication (written, verbal etc) with the clinic including but not limited to intake forms, consent forms, policy forms, EHC billing forms, and imaging request forms. By signing below you agree to this policy.

Privacy & Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or other third parties as deemed necessary for the management of my case. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission. By signing below you agree to this policy.

Cancellations & Missed Appointments

A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, may be charged a cancellation fee. If appointments are repeatedly missed/cancelled, we will, regretfully have to dismiss the patient from care. By signing below you agree to this policy.

Health Education

We have found that when patients take an active role in their health they tend to experience better outcomes. This is why we offer additional health services including a monthly newsletter and blog service. It is our policy that our patients start receiving this service, however they can unsubscribe at any time. By signing below, you have agreed to this policy.

Payment Schedule

It is the responsibility of the patient/guardian to pay the balance on their account at the time the services are rendered. If insurance claims are being submitted on your behalf, you are responsible for any outstanding balance. Should you incur additional charges, the balance must be payed prior to commencement of care. If for any reason that it is necessary to discontinue your care, any outstanding fees will become due and payable immediately. By signing below you agree to this policy.

I have read and understand Complete Care Chiropractic's offices policies. I hereby agree with these policies & services. I understand that this document applies to all services that I choose to partake in at the clinic at this time and to any of the services I choose to receive at this clinic in the future.

Date: _____ / _____ / _____

Print:_____ (Patient/Guardian) Sign:_____ (Patient/Guardian)