Alexandra Tarkowski, BHSc, DC

The Massage Clinic Health Centres

Please be advised all Information is private and confidential

Contact Information

□ Mr. □ Mrs. □ Miss □ Ms. □ Dr. □ Sir

Name: _____
First Name Last Name

Address: _____

City: _____ Province: _____ Postal Code:_____

Phone #: Home: _____Work: _____ Cell: _____

Email: _____ Date of Birth: Day_____Month_____Year_____

Gender: □ Male □ Female

Occupation: _____ Hrs/week: _____ Work posture: _____

Emergency Contact Name: _____ Phone #: _____

Emergency Contact's Relationship to You: _____

Medical Information

Family Physician: _____ Phone: (____)_____

Address: _____

City: _____Province: _____ Postal Code:_____

Previous Treatment:

□ Athletic Therapist □ Chiropractor □ Massage Therapist □ Acupuncturist □ Other

Name (or Clinic Name):_____ Date of Last Visit: _____

How did you hear about us?

□ Bell Yellow Pages □ Other Yellow Pages □ Internet
□ Yellowpages.ca □ White Pages □ Website
□ Advertisement (Location):_____ □ Referral:_____
□ Walk In □ Other: _____

Chief Complaint

Reason for this appointment? (Chief Complaint) _____

When did your condition begin? _____

Is this condition related to: □ Occupation □ Car Accident □ Fall □ Sports Injury □ Other

Has this condition occurred before: □ Yes □ No

Are you currently taking any medication for this condition?: □ Yes □ No

Have you seen a health care professional for this condition?: □ Yes □ No

If yes, who?: _____

When is your pain the worst? □ Morning □ Mid-day □ Evening □ All day

What aggravates your pain? _____

What relieves your pain? _____

Does the pain affect your work, family life or recreational activities? □ Yes □ No

Does this condition cause you anxiety, stress, and / or depression? □ Yes □ No

Have you had any advanced tests performed for this condition? *(X-Rays, CT, MRI, Nerve Conduction Study, Ultrasound etc…)*

□ Yes □ No If yes: Date: _____ Testing type: _____

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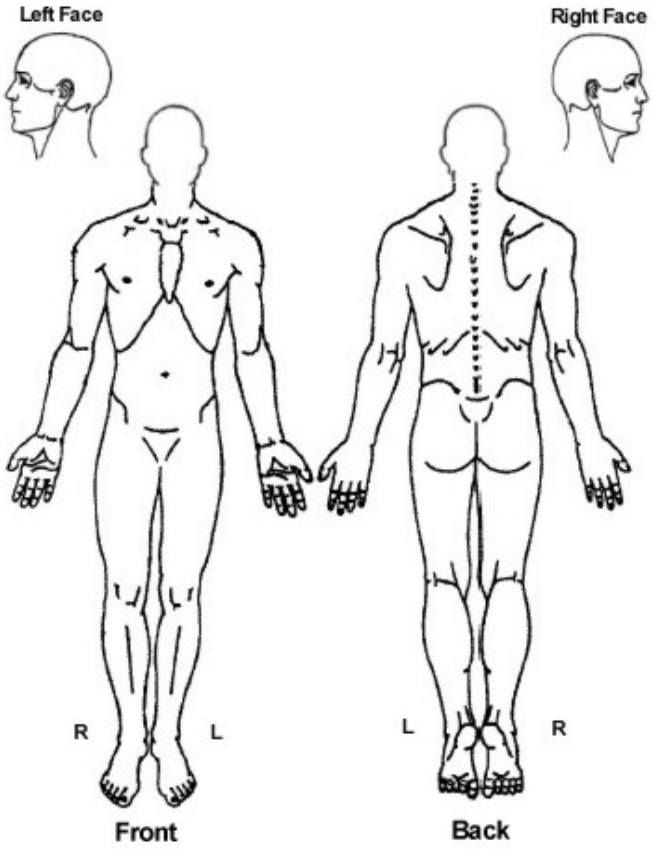
Symptom Diagram

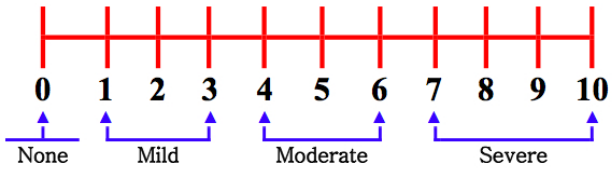
On the diagrams below, please outline the area(s) of discomfort. Please use symbols provided that best represent the pain or sensation(s) you are experiencing.

Symbols:

Numbness:	_____ _____	Pins & Needles:	:::::::::::: ::::::::::::	Burning:	xxxxxxxx xxxxxxxx
Stabbing & Sharp:	ooooooo ooooooo	Dull & Aching	+++++++ +++++++	Stiff & Tight:	2222222 2222222



Please indicate your level of pain along the line below with an ‘x’. 0 represents no pain and 10 represents the worse pain you have ever felt.



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Lifestyle

Please check all that apply:

- ❑ alcohol No. of drinks (e.g. wine, spirits, beer) per week: _____
- ❑ caffeine No. of drinks (e.g. coffee, tea) per day: _____
- ❑ smoking No. of cigarettes per day: _____
- ❑ exercise No. of hours per week: _____ Type(s) of Exercise: _____

List all allergies, if any: *(food, environmental, etc.):* _____

Medical History

Previous hospitalizations: _____

Have you had any surgeries?: _____

History of major injuries:(MVA, dislocation, sprain, fracture, etc.) _____

Do you have all of your standard vaccinations? □ Yes □ No

For Women: No. of Pregnancies:_____ No. of children: _____ Are you pregnant: □ Yes □ No

Are you currently taking any medications on a regular basis? Please indicate medication name and dosage;

_____

_____

Do you have or have you ever had any of the following?

□ Cancer
□ Anemia
□ Diabetes Type 1
□ Diabetes Type 2
□ Stroke
□ Heart Disease
□ Pleurisy
□ Arthritis
□ Rheumatoid Arthritis
□ Influenza
□ Psoriasis
□ Tuberculosis
□ Eczema
□ Rheumatic Fever
□ Gall stones
□ Kidney stones
□ Sensitive skin
□ Problem acne
□ Dermatitis
□ Venereal disease
□ Measles
□ Polio
□ Thyroid condition
□ Pneumonia
□ Blood clot (DVT)
□ Poor circulation
□ Phlebitis
□ Plantar warts: hands or feet
□ Hepatitis
□ Liver disease
□ Mumps
□ Chicken pox
□ Shingles
□ Crohns
□ Colitis
□ Rashes
□ Skin infection
□ HIV / AIDS
□ Lung disease
□ Kidney disease
□ Rubella
□ Epilepsy
□ Seizures
□ Congestive Heart Failure
□ Varicose Veins
□ Bleeding disorder
□ Bruise easily
□ Headaches
□ High / low blood pressure
□ Mental health condition
□ Hernia

Please check any of the following you have experienced within the past six months:

General
□ Fatigue
□ Allergies
□ Difficulty sleeping
□ Fever
□ Diarrhea

Eyes, Ears, Nose, Throat
□ Sore throat
□ Dental problems
□ Vision impairment
□ Ear ache
□ Hearing difficulty
□ Ringing in ear

Gastro-Intestinal
□ Poor/excessive appetite
□ Vomiting
□ Frequent nausea
□ Excessive thrist
□ Weight gain/loss
□ Constipation
□ Heartburn
□ Black/bloody stool
□ Gall bladder disorders
□ Abdominal cramps
□ Gas/bloating with meals

Cardiovascular
□ Chest pain
□ Shortness of breath
□ High blood pressure
□ Low blood pressure
□ Dizziness
□ Lung disorders
□ Chest congestion
□ Blackouts/fainting
□ Irregular heart beat

Male/Female
□ Menstrual irregularity
□ Breast pain/lumps
□ Menstrual cramps
□ Prostate enlargement

Genito-Urination
□ Painful/excessive urination
□ Bladder dysfunction
□ Urine discoloration

Is there a family history of any of the following diseases?

□ Cancer
□ Anemia
□ Diabetes Type 1
□ Diabetes Type 2
□ Stroke
□ Heart Disease
□ Arthritis
□ Rheumatoid Arthritis
□ Psoriasis
□ Eczema
□ Dermatitis
□ Headaches
□ Mental illness
□ Substance abuse
□ High / low blood pressure
□ Thyroid condition
□ Blood clot (DVT)
□ Poor circulation
□ Phlebitis
□ Hepatitis
□ Liver disease
□ Crohns
□ Colitis
□ HIV / AIDS
□ Lung disease
□ Kidney disease
□ Substance abuse
□ Epilepsy
□ Seizures
□ Congestive Heart Failure
□ Varicose Veins
□ Bleeding disorder
□ Bruise easily
□ Allergies

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Fee Schedule

Chiropractic Services

Assessment (Initial)	$100.00 Total
Treatment	$60.00 / 20 min, $70.00 / 30 min

Types of services

- Active Release Techniques (ART ®)
- Manual Therapy, Soft Tissue Mobilization
- Medical Acupuncture
- Functional Rehabilitation, Exercise Preparation
- Taping, Orthotics, Bracing

Additional Statements

Please read the following and check off each circle indicating that you agree with each statement. Please sign below.

- o I have completed all questions and areas where information has been requested. The information that I have provided is accurate and complete. I understand that the withholding of health care information could jeopardize my receiving safe and effective treatment.

- o In the event I am not able to answer the phone when called by the staff of The Massage Clinic Health Centres, I hereby authorize the staff to leave a message for me regarding appointment information at the phone numbers provided.

- o The team at The Massage Clinic Health Centres often collaborates with each other regarding their patients' diagnosis and treatment. In the event that this is required, I hereby consent to allowing my health care provider to collaborate with others within The Massage Clinic.

- o Out of respect to our practitioners and their schedules, we require 24 hours notice for all cancellations. Any cancellations without 24 hours notice or missed appointments will be subject to a cancellation fee of the full cost of the booked appointment. This fee is applied and/or waived at the discretion of the practitioner. We appreciate your understanding.

- o Chiropractic treatment may be covered under extended health insurance, and or no fault insurance such as motor vehicle accident or WSIB. However, in the event that the third party billing does not cover my treatment fees I hereby confirm that I am responsible for any outstanding balance.

- o I consent to being examined by: _____

SIGNATURE: _____ PRINTED NAME: _____

WITNESS SIGNATURE:_____ WITNESS: _____

DATE: _____ DATE: _____