WESTHILLS CHIROPRACTIC
MASSAGE AND SPORTS THERAPY
MOVE BETTER FEEL BETTER LIVE BETTER

CLINIC INTAKE FORM

Date:

Name:

Address:

City: Postal Code:

Phone: Home: Cell:

Email:

(email address is used for appointment reminders and receipts)

Date of Birth (mm/dd/year) Age:

Biological Sex: Please Select

Alberta Health Care Number:

Occupation:

Referred to our office by; (Friend, Location, MD, etc) Please Select

Do you have any third-party insurance (Blue Cross, Sunlife etc): Please Select

If you have 3rd party insurance - please complete Extended Health Form

Emergency Contact Name: Phone Number:

PATIENT SIGNATURE:

WESTHIILS TOWNE CENTER
129 STEWART GREEN SW
CALGARY, AB. T3H 3C8

(403) 217-4480

WWW.WESTHILLSCHIROPRACTIC.CA

WESTHILLS CHIROPRACTIC & MASSAGE
129 STEWART GREEN SW. CALGARY, AB. T3H 3C8
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(403) 217-4480

Massage Intake Form

Patient Name: Date:

Please describe your concern?

How long have you had this condition?

Do you know what caused the problem?

When do you experience the problem?

How long do the symptoms last?

Is there anything that relieves the pain?

Have you had the issue before? Please Select if Yes, please explain:

Please rate your following levels:

Pain: Please Select Stress: Please Select Activity: Please Select

Location of Symptoms

please select the type and location of your symptoms at this time.

1.	Please Select	Please Select	Please Select
2.	Please Select	Please Select	Please Select
3.	Please Select	Please Select	Please Select
4.	Please Select	Please Select	Please Select
5.	Please Select	Please Select	Please Select

Massage Intake Form

Patient Name: _____ Date: _____

Have you ever been in a Motor Vehicle Accident? No If Yes, When _____

Have you had any other injuries or surgery? _____

Allergies / Medications: _____

Activities: (walking, golf, computer, sports, sewing, etc.) _____

On a scale of Poor – Fair - Good - Excellent, describe your:

Diet Please Select Exercise Please Select

Sleep Please Select General Health Please Select

History of Cancer? No Are you Pregnant? No Due: _____

Last Massage: _____

Preferred Style of Massage (Relaxation, Deep Tissue): Please Select

Medical Doctor: _____ Chiropractor: _____

Health History:

Please check the appropriate box for any of the following symptoms which you have now or have had previously

O = Occasional F = Frequent C = Constant

O	F	C	Nervous System
☐	☐	☐	numbness /
☐	☐	☐	tingling chronic
☐	☐	☐	pain herpes /
☐	☐	☐	shingles fatigue
☐	☐	☐	sleep disorders

O	F	C	Digestive
☐	☐	☐	constipation
☐	☐	☐	diarrhea
☐	☐	☐	gas / bloating
☐	☐	☐	diverticulitis
☐	☐	☐	Irritable bowel syndrome

O	F	C	Musculoskeletal
☐	☐	☐	bone or joint disease
☐	☐	☐	tendinitis
☐	☐	☐	bursitis
☐	☐	☐	broken / fractured bones
☐	☐	☐	arthritis
☐	☐	☐	sprains / strains
☐	☐	☐	low back, hip, leg pain
☐	☐	☐	neck, shoulder, arm pain
☐	☐	☐	spasms / crampts
☐	☐	☐	jaw pain / TMJ
☐	☐	☐	flat feet / high arches

O	F	C	Circulatory
☐	☐	☐	heart condition
☐	☐	☐	varicose veins
☐	☐	☐	blood clots
☐	☐	☐	high blood
☐	☐	☐	pressure low
☐	☐	☐	blood pressure
☐	☐	☐	lymphedema

O	F	C	Skin
☐	☐	☐	dryness
☐	☐	☐	bruises easily
☐	☐	☐	allergies
☐	☐	☐	rashes
☐	☐	☐	athletes foot
☐	☐	☐	warts

O	F	C	Respiratory
☐	☐	☐	chest pain
☐	☐	☐	chronic cough
☐	☐	☐	difficulty breathing
☐	☐	☐	asthma
☐	☐	☐	allergies
☐	☐	☐	ear aches

O	F	C	Genito-Urinary
☐	☐	☐	pregnant
☐	☐	☐	PMS
☐	☐	☐	menopause
☐	☐	☐	frequent urination
☐	☐	☐	kidney infection
☐	☐	☐	painful urination
☐	☐	☐	prostate trouble

O	F	C	Other
☐	☐	☐	cancer / tumors
☐	☐	☐	diabetes
☐	☐	☐	mental health condition
☐	☐	☐	poor nutrition
☐	☐	☐	drug/alcohol consumption
☐	☐	☐	nicotine
☐	☐	☐	caffeine

Family History

Condition	(Relationship to you)
Diabetes	_____
Arthritis	_____
Heart Disease	_____
Stroke	_____