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, receipts)

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

Biological Sex: Female / Male / Non-Specified

Alberta Health Care Number: _____

Occupation: _____

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

Do you have any third-party insurance (Blue Cross, Sunlife etc): YES NO

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
WWW.WESTHILLSCHIROPRACTIC.CA
(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? No / Yes: if Yes, please explain: _____

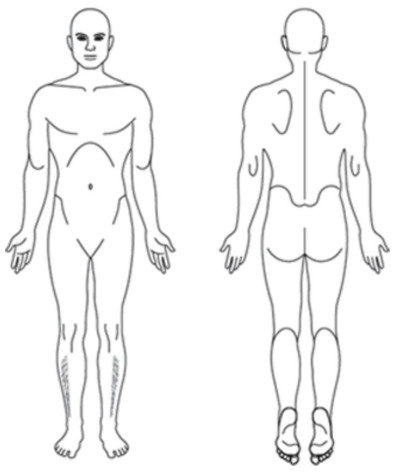
Using an "X" mark on the line below where you describe your

Pain:	No Pain	I--- I --- I --- I --- I --- I --- I --- I --- I --- I --- I	Worst Pain
Stress:	No Stress	I--- I --- I --- I --- I --- I --- I --- I --- I --- I --- I	Extreme Stress
Activity Level:	No Activity	I--- I --- I --- I --- I --- I --- I --- I --- I --- I --- I	High Activity

Location of Symptoms

On the body diagram using the letters below, mark the type and location of your symptoms at this time.

A = Aching Pain
B = Burning Pain
N = Numbness
P = Pins and Needles
S = Stabling Pain



Massage Intake Form

Patient Name: _____ Date: _____

Have you ever been in a Motor Vehicle Accident? No / Yes 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 _____ Exercise _____

Sleep _____ General Health _____

History of Cancer? YES / NO Are you Pregnant? YES / NO Due: _____

Last Massage: _____

Preferred Style of Massage (Relaxation, Deep Tissue): _____

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
☐	☐	☐	tendonitis
☐	☐	☐	bursitis
☐	☐	☐	broken / fractured bones
☐	☐	☐	arthritis
☐	☐	☐	sprains / strains
☐	☐	☐	low back, hip, leg pain
☐	☐	☐	neck, shoulder, arm pain
☐	☐	☐	spasms / cramps
☐	☐	☐	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	_____