WestHills Chiropractic & Massage
129 Stewart Green SW. Calgary, AB. T3H 3C8
www.WestHillsChiropractic.ca
(403) 217-4480

Date: _____

Name: _____

Address: _____

City: _____ Postal Code: _____

Phone: Home: _____ Work: _____

Cell: _____ Other: _____

Email: _____

Date of Birth: _____ Gender: Female / Male

Alberta Health Care Number: _____

Occupation: _____

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

Do you have any third party insurance - (Blue Cross, Sun Life, Great West Life, etc)?

Insurance Company: _____

Name on Policy: _____

Policy Number: _____

ID Number: _____

Emergency Contact:

Name: _____ Phone Number: _____

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WWW.WESTHILLSCHIROPRACTIC.CA
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Massage Intake Form

Patient Name: _____ Date: _____

Please describe the location, length of time and severity of your concern?

_____

_____

_____

Do you know what causes the problem? _____

When do you experience the problem? (ie Sleep? Morning? After Activity?)

_____

Describe the pain: (sharp, dull, burning, numbness, tingling, aching, stabbing, etc)

_____

How long does the pain last? _____

Is there anything that relieves the pain? _____

Have you had any other injuries or surgery? If so, please explain _____

_____

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

Allergies: _____

Medication: _____

Medical Doctor: _____

Chiropractor: _____

History of Cancer? Yes / No

Are you H.I.V.+ ? Yes / No

Are you Pregnant? Yes / No

Due Date: _____

Massage Health History Form

Patient Name: _____ Date: _____

Please check off any of the following that apply to you:

- ☐ Low Back Pain
- ☐ Headache
- ☐ Fatigue
- ☐ Osteoporosis
- ☐ Swelling of Joints
- ☐ Spine Tender to Touch
- ☐ Morning Stiffness
- ☐ Multiple Joint Pain
- ☐ Bone Pain
- ☐ Fractured Vertebrae
- ☐ Rheumatoid Arthritis
- ☐ Fainting
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Attack
- ☐ Stroke
- ☐ Chest Pain
- ☐ Diabetes
- ☐ Respiratory / Urinary Infection
- ☐ Abdominal Pain
- ☐ Asthma
- ☐ Brain Tumors
- ☐ Skin Conditions
- ☐ Varicose Veins
- ☐ Dizziness
- ☐ Numbness / Tingling
- ☐ Crunching / Grinding
- ☐ Pin, Plants or Prosthesis
- ☐ Color changes in fingers / toes
- ☐ Weakness of Arm / Leg / Hand / Foot

Please indicate any conditions not mentioned above: _____

_____

Clinic Policy

1. Please arrive 5 – 10 minutes prior to the scheduled appointment in order for your massage to begin on time.
2. Arriving late may result in not receiving the fully allotted time. Full charges will still apply.
3. 24 Hours notice is required for cancellation of an appointment – otherwise the full fee may be charged.
4. Payment for massage therapy treatments is to be made as services are rendered.
5. Please inform you're therapist of any changes in your health, medication, or recent injuries.