



In GreatHands

Chiropractic & Wellness Centre

Inside Oshawa Centre Mall
C/O Goodlife, 419 King Street West, Oshawa, ON L1J 2K5
Phone: (905) 433-9520 Fax: (905) 433-8144
Email: oshawa@ingreathands.com Website: www.ingreathands.com

Welcome

You are in GreatHands.

MASSAGE THERAPY – YOUR HEALTH PROFILE

Answering the following questions will give us an idea of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

PATIENT INFORMATION

Name: _____
Address: _____
City: _____ Prov.: _____ Postal Code: _____
E-mail: _____
SIN #: _____
Driver's License #: _____
Date of Birth: _____ Age: _____ Sex: M F
 Single Married Divorced Widowed
 # of Children: _____
Occupation: _____
Business/Employer: _____
Is there any chance that you are pregnant? Y N
How did you hear about our office? (if someone referred you, please let us know so that we can thank them!) _____

PHONE NUMBERS

Home#: () _____ Cell#: () _____
Work#: () _____ Ext. _____
Best time and place to reach you: _____

In case of emergency, contact:

Name: _____
Relationship: _____
Home#: () _____ Work#: () _____
Cell #: () _____

INSURANCE

Do you have private health insurance? Y N

Insurance Provider: _____
Policy #: _____
ID #: _____

CURRENT HEALTH

1. Check any of the following symptoms you have had in the last 12 months, even if they do not seem related to your current problem.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> low back pain | <input type="checkbox"/> flat feet | <input type="checkbox"/> allergies | <input type="checkbox"/> cancer |
| <input type="checkbox"/> shoulder pain | <input type="checkbox"/> shin splints | <input type="checkbox"/> digestive problems | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> elbow pain | <input type="checkbox"/> tired / fatigue | <input type="checkbox"/> ankle / foot pain | <input type="checkbox"/> asthma |
| <input type="checkbox"/> neck pain | <input type="checkbox"/> ringing in the ears | <input type="checkbox"/> wrist / hand pain | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> knee pain | <input type="checkbox"/> weight loss | <input type="checkbox"/> difficulty sleeping | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> obesity | <input type="checkbox"/> heart disease /pacemaker | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> achilles tendonitis | <input type="checkbox"/> calluses / bunions | <input type="checkbox"/> pain between the shoulder blades | |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> headaches / migraines | <input type="checkbox"/> tension across the top of shoulders | |
| <input type="checkbox"/> numbing or tingling in arms / hands | | | |

Which of the above is the worst? _____ How long have you had it? _____

When is it at its worst? _____

How does it feel? (sharp / dull / achy / pins & needles / numbness) _____

2. Do these symptoms interfere with your

- work sleep walking
 sitting hobbies leisure

3. Other professionals you have seen for this problem:

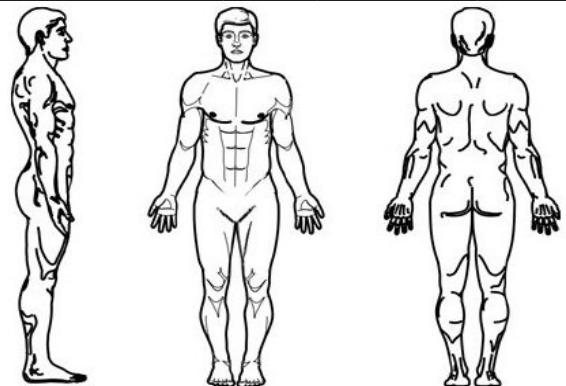
- chiropractor physiotherapist MD
 other _____

Is this condition: Job related / WSIB Motor Vehicle Accident

(If you have marked either of these two options, PLEASE INFORM THE FRONT DESK)

Mark where the problem is on the diagram with an X or a circle, and please describe what it feels like.

Sharp / Dull / Achy / Stabbing



HEALTH HISTORY

Growth / development and health habits

Surgery? Y N
Medications? Y N
Did / do you smoke? Y N
Did / do you drink alcohol? Y N
Did/ do you take recreational drugs? Y N
Have you been in any accidents as child? Y N
Have you been any accidents as an adult? Y N
Vaccinations? Y N
As a child, were you under regular chiropractic care? Y N
Do you play any adult sports? Y N
Do you participate in extreme sports? Y N
Are you physically active? Y N
Would you be interested in becoming more active? Y N

Please explain:

Please mark the choice that best describes your:

Stress level high moderate low
Diet excellent good poor
Exercise excellent good poor
Sleep excellent good poor
General health excellent good poor

Medical Doctor/Family Physician's Name:

Phone#: () _____
Address: _____

Have you ever received chiropractic care? Y N

If yes, how long ago? _____
How often did you go? _____
Chiropractor's name: _____
Phone#: () _____
Date of last visit: _____

Have you ever received massage therapy care? Y N

If yes, how long ago? _____
How often did you go? _____
Massage Therapist's name: _____
Phone#: () _____
Date of last visit: _____

As a thank you for coming into our clinic, you can receive a 5-day pass at Goodlife Fitness. Are you interested in having a membership consultant contact you for your initial consultation? Y N

The Above Information is True and Accurate to the Best of my Knowledge

Print Name

Signature

Date