LANSDOWNE
massagetherapyclinic

PATIENT INTRODUCTION FORM & CLINICAL RECORD
(please print)

Name: ______________________________ Age: _________ Birth date: ____/____/____/ (MM/DD/YY)

Address: ______________________ City:__________ Postal Code:__________ Home phone:____________

Personal Health Number: ______________ Occupation: ______________ Business Phone: ______________

Employed by: ____

Doctor's Name: ______________ Doctor's billing #: ________ Doctor's Phone: __________ Referred by: ________

Have you seen a chiropractor: __ physiotherapist: ___ massage therapist: ____ who? ____________ when?__________

Where did you hear about our clinic? ____

If this is the result of a motor vehicle accident, please provide the following information:

ICBC claim #: ________________ Adjustor's Name: ________________ Location: ________________

Phone: ______________ Date of accident: ____________

CHIEF COMPLAINT: (briefly describe)

____

____

____

Duration of problem: _______ What relieves the condition? ________________________________
What aggravates the condition? ____

Have you ever had any falls, accidents or injuries? Yes: ___ No: ____
If yes, please explain (give month & year): ____
____

Have you ever had any surgery? Yes: ___ No: ____
If yes, please explain (give month & year): ____
____

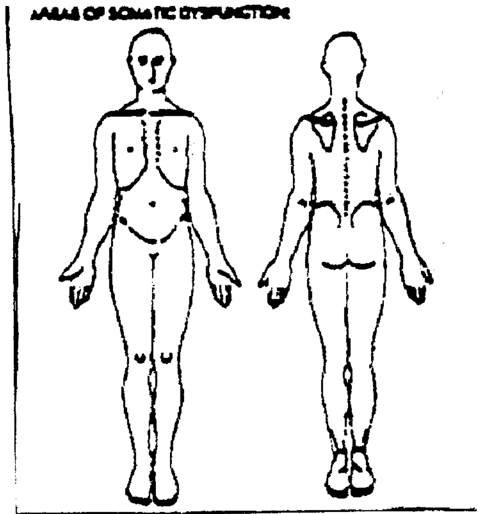
Are you presently taking medication? Yes:___ No:___
If yes, please give type, dosage and what it's for:_____________________________________
____
____

Do you have any of the following? Diabetes: ___ Arteriosclerosis: ____ Cancer: _____ Heart disease: _____ Hemophilia: ____
Infectious or Contagious Disease: ___ T.B: _____

Briefly Comment On:

EatingHabits: ____
Exercise: ____
Sleeping Patterns: ____

TURN OVER



PLEASE INDICATE AREAS OF :

1) Pain +++++

2) Numbness /////

3) Tingling XXXXX

PLEASE CIRCLE ANY CONDITIONS WHICH APPLY TO YOU:

HEAD / NECK

headache	vision problems	wear contacts		
allergies	frequent colds	earache	depression	ringing in ears
deafness	thyroid	shooting head pains	lights bother eyes	loss of balance
sinus trouble	loss of smell	loss of memory	fatigue	

RESPIRATORY

chest pain	chronic cough	shortness of breath	asthma	chest tightness
emphysema	pulmonary disease	smoking		

CARDIOVASCULAR

poor circulation	swelling of ankles	varicose veins	fainting	dizziness
stroke	atherosclerosis	chest pains	anemia	high / low blood pressure
heart attacks				

DIGESTIVE

nervous stomach	nausea	loss / gain weight	indigestion	ulcer
belching / gas	liver/gallbladder	kidney / bladder	constipation	loose bowel movement

MUSCLES & JOINTS

fractures	painful joints	rods / pins	arthritis	slipped disc
pinched nerves	stiff neck	backache	tension	limited range of motion
tingling	numbness	joints swollen / stiff	pain in shoulders / elbow / wrist / hand	
pain in SI joint / hip / knee / ankle / foot				

YOUR APPOINTMENT: Time is reserved especially for you. If you find it necessary to reschedule an appointment, a minimum of 24 hours notice is required so we may give this time to someone else. Otherwise it will be necessary to charge you **$25.00 per 1/2 hour**, for lost time. Thank-you.

If billing is refused by a third party (i.e.; VA, ICBC, RCMP, WCB) you will be responsible for the full cost of treatments provided.

Date: ______________ Signature: ____

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