Temple Crossing Chiropractic and Massage
204 – 5401 Temple Drive NE
(403) 280-8992 / (403) 293-1288
www.templechiro.com

Confidential New Patient Form

Name: _____ Phone: Home - _____

Address _____ Work - _____

City/Prov: _____ Cell - _____

Postal Code: _____ Date of Birth: _____

E-mail address: _____

Referred by _____

Occupation: _____ Marital Status - _____

Primary Health Care Provider: _____ Phone: _____

Permission to consult with health care provider: Yes: _____ No: _____

Physician's Prescription note: **Yes**: _____ **No**: _____

Past History (include description & date)
Surgeries/operations: _____

Accidents/falls/injuries_____

List current medications (including aspirin, ibuprofen, antihistamines, birth control, etc.) _____
_____

Please check the appropriate box for any of the following conditions you currently have.
Please underline any of the following conditions that you have had in the past.

Musculoskeletal
- ☐ Bone or joint disease
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Broken/fractures bones
- ☐ Arthritis
- ☐ Sprain/strains
- ☐ Low back/hip/leg pain
- ☐ Neck/shoulder/arm pain
- ☐ Headaches/head injuries
- ☐ Spasms/cramps
- ☐ Jaw pain/TMJ
- ☐ Flat feet/high arches

Circulatory
- ☐ Heart conditions
- ☐ Varicose veins
- ☐ Blood clots
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Lymphedema

Infectious Diseases:
Names: _____

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Asthma
- ☐ Allergies
- ☐ Ear aches

Nervous System
- ☐ Numbness/tingling
- ☐ Chronic pain
- ☐ Herpes/shingles
- ☐ Fatigue

Genito-urinary
- ☐ Pregnant

How many mths? _____
- ☐ PMS
- ☐ Menopause
- ☐ Frequent urination
- ☐ Kidney infection
- ☐ Painful urination
- ☐ Prostrate trouble

Digestive
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas/bloating
- ☐ Irritable bowel syndrome

Skin
- ☐ Dryness
- ☐ Bruise easily
- ☐ Rashes
- ☐ Athletes foot
- ☐ Warts

Other
- ☐ Cancers/tumors
- ☐ Diabetes
- ☐ Mental health conditions
- ☐ Poor nutrition
- ☐ Drug/alcohol consumption
- ☐ Caffeine

Any other conditions not listed? _____

_____

Massage History / Treatment Information

Have you ever received a professional massage? No: _____ Yes: _____ Date of last massage: _____

What results do you want to come from your massage session? _____

_____

Current Concerns:

_____

_____

Describe the onset:

_____

_____

Are you currently being treated by anyone else for this complaint? If yes, with who?

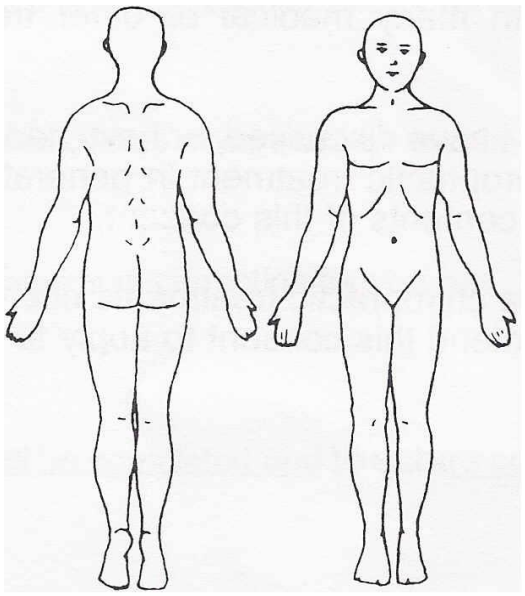
_____

On the diagram below, please indicate the areas where you are experiencing pain or unusual feeling.

Legend:	
Numbness:	O
Stiffness:	//
Pain:	X

Rate your pain on a scale from 1-10.
(1 being not much pain, 10 being severe pain.)

1....2....3….4….5....6….7....8....9....10



Please read the following:

*** *It is the policy of Temple Crossing Therapeutic Massage that payment is made at the time of service. Receipts are provided for the patient to arrange reimbursement* ***

I understand that massage is given here for the purpose of stress reduction, relief from muscular tension, spasm or pain, and the increase of circulation and/or energy flow.

I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorders. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulations. It has been made clear to me that massage therapy is not a substitute for medical examinations, diagnosis, or treatment and it is recommended that I see a chiropractor or medical doctor for any physical ailment I might have.

I understand that I need to give 24 hours notice to change or cancel my massage, or else I may be charged the price of half my massage fee.

I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated in my physical health.

I understand that insurance is billed as a courtesy to me, any amounts not collected are my responsibility to be paid at the time of notice.

Date: _____

Name: (please print)_____

Signature:_____