Michelle Wilson, MO, RMT, CLT
Manual Osteopath
Registered Massage Therapist
Certified Lensen Therapist

Bow River Chiropractic Clinic

Patient Information

Name:_____ Date of Birth: (mm/dd/yy) ____/____/____ Age: _____

Address: _____ City: _____ Postal Code: _____

Phone #: (primary) _____ (secondary) _____

e-mail: _____ Occupation/Type of Work: _____

Emergency Contact/Relationship: _____ Phone #:_____

Health History

Current medications (and conditions they treat): _____

_____

Surgeries (list and approximate date): _____

_____

Location/presence of artificial joints, internal pins, plates, wires, other special equipment: _____

_____

Motor vehicle accidents (approximate date): _____

_____

Other accidents (torn muscles, sprains, breaks, dislocations, head injury, etc.): _____

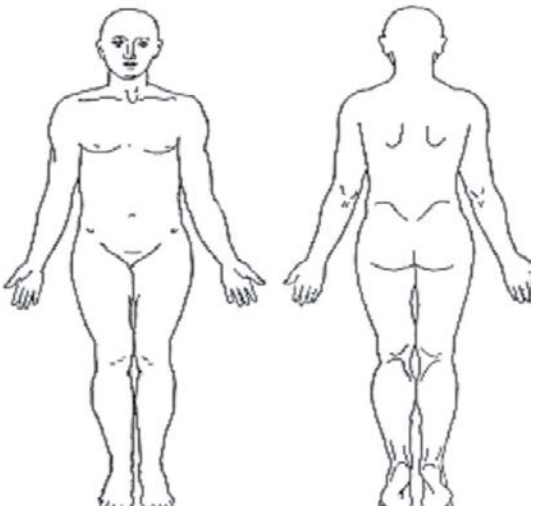
_____

_____

Other medical professionals you are currently being treated by (chiropractor, physiotherapist, etc.):

_____

Indicate areas of pain or discomfort:



Notes:

_____

_____

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_____

_____

Please Check All Applicable Boxes:

Musculo-skeletal

- ❑ Bone/Joint disease
- ❑ Tendonitis
- ❑ Bursitis
- ❑ Fractures
- ❑ Osteoarthritis
- ❑ Rheumatoid-arthritis
- ❑ Sprains/strains
- ❑ Swelling
- ❑ Stiffness
- ❑ Spasms/cramps
- ❑ Pain
  Area(s):_____
  _____

Respiratory

- ❑ Chronic cough
- ❑ Bronchitis
- ❑ Shortness of breath
- ❑ Asthma
- ❑ Emphysema
- ❑ Other:_____

Skin

- ❑ Allergies:_____
  _____
- ❑ Rashes
- ❑ Athletes foot
- ❑ Warts
- ❑ Cold sores
- ❑ Eczema/psoriasis
- ❑ Other:_____
  _____

Digestive

- ❑ Constipation
- ❑ Gas/bloating
- ❑ Nausea/vomiting
- ❑ IBS
- ❑ Liver/gallbladder
- ❑ Kidney/bladder
- ❑ Other:_____

Cardiovascular

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chronic congestive heart failure
- ❑ Heart disease
- ❑ Myocardial infarction
- ❑ Phlebitis
- ❑ Cardio-vascular accident
- ❑ Stroke
- ❑ Pacemaker
- ❑ Varicose veins
- ❑ Blood Clots
- ❑ Lymphedema
- ❑ Other:_____

Infectious Diseases

- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ HIV
- ❑ Other:

Nervous System

- ❑ Herpes/shingles
- ❑ Numbness/tingling
- ❑ Chronic pain
- ❑ Fatigue
- ❑ Sleep disorder
- ❑ Loss of sensation
- ❑ Other:_____

Other

- ❑ Addictions:
  Drug / alcohol / nicotine
- ❑ Diabetes
- ❑ Vision/hearing loss
- ❑ Cancer
- ❑ Epilepsy
- ❑ Headaches/migraines
  How often: _____

Reproductive

- ❑ Pregnancy
  Due Date:_____

Client Consent Statement

In keeping with the Health Care Consent Act (1996), it is my choice to receive therapy. I understand that an assessment by a therapist is required to determine the best course of treatment. I am aware that all information provided is private and confidential and will not be released without my written consent. I agree to communicate with my therapist at any time I have any questions, if I feel uncomfortable, or I feel that my well being is being compromised. I will consent to the therapist working only on those areas of my body that I am comfortable with. I am aware that I may remove only the clothing with which I am comfortable and may terminate the treatment at any time at my discretion. I understand and am aware of the posted fees and cancellation policy. I am also aware of the possible side effects from a treatment such as temporary muscular discomfort (24-48 hours post treatment) and possible headaches and dizziness. I understand the therapist will recommend remedial exercises and home care. I am aware that the clinic is not responsible for any lost, stolen or damaged articles.

Cancellation Policy

We require 24 hours notice if you are unable to make your scheduled appointment.
After an initial warning, all subsequent missed appointments will then be billed at the regular fee.

Signature (18 years of age or older): _____ Date: _____

Parental/Guardian Signature: _____ Date: _____