we-fix-u.com

WELCOME! Please Print Clearly and Fill Out This Form Completely. Return to Our Receptionist As Soon As Completed.

PATIENT INFORMATION:

LAST NAME:_____ **FIRST NAME:**_____ **SEX: ❑M ❑F**

PARENT/GAURDIAN NAME:_____

MAILING ADDRESS:_____ **CITY:**_____ **POSTAL CODE:**_____

****E-MAIL ADDRESS**:**_____

HOME PHONE: ( )_____ **AGE:**_____ **Date of Birth:** _____ / _____/ _____
CELL PHONE: _____ *Month Day Year*

EMPLOYER:_____ **PHONE: ( )**_____**EXT**_____

OCCUPATION:_____ **MAY WE CALL YOU AT WORK? ❑Y ❑ N** **HOURS:**_____

WHO IS YOUR FAMILY DOCTOR?_____ Phone (if not local)_____

DOCTORS ADDRESS_____

DO YOU SEE ANY OTHER MEDICAL SPECIALISTS? If yes, who and for what problem? _____
_____

IN CASE OF EMERGENCY:

WHO SHOULD BE NOTIFIED?_____**RELATIONSHIP:**_____**PHONE ( )**_____

WHAT MADE YOU DECIDE TO COME TO OUR CLINIC?

We need your help to make sure we allocate our promotional budget to the best resources. Please tell us what made you decide to choose our clinic instead of another one (Choose one):

❑ Your doctor/specialist told you to come
Who is your Doctor?_____

❑Your Friend/Relative told you about this clinic
Who is your friend/relative? _____

❑ You heard our ad on the radio
Which station?_____

You saw our ad in the: ❑Yellow Pages ❑Large Print Phone Book ❑ Newspaper (Which One?):_____
❑Magazine (Which One?):_____

❑You saw our sign ❑You saw us at an event
Which event?_____ ❑Google Search/Website ❑Social Media (i.e. facebook)

❑You have been a patient here before and you decided to come back because you like us so much =)

❑ Another We-Fix-U Staff told me to come
❑ Other (please tell us):_____

PLEASE TURN PAGE OVER…We have questions about your health……

MASSAGE HEALTH HISTORY FORM

The information requested below will assist us in treating you safely. If your health status changes, please notify your RMT. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

Which hand do you write with? L ☐ R ☐

Do you sleep on your: Back ☐ Side ☐ Stomach ☐

Have you had massage therapy before? Y ☐ N ☐

Are you currently receiving treatment from another health care practitioner? Yes ☐ No ☐

If yes; please indicate for what and with whom :_____

_____

Please list all exercise you are involved in: _____

When getting a massage what kind of pressure do you prefer?
Light ☐ Moderate/Medium ☐ Deep ☐ Very deep ☐ Unsure ☐

CONSENT FOR TREATMENT

I understand that Registered Massage Therapists do not diagnose illness, disease or any mental/physical disorder; nor do they prescribe medical treatment pharmaceuticals or perform spinal thrust manipulations. I have stated all medical conditions that I am currently aware of and will update the Massage Therapist of any changes in my health status.
I acknowledge I have discussed or have had the opportunity to discuss with my RMT the nature and purpose of my treatments (s). I consent to the registered massage therapy treatments offered or recommended to me by my RMT. I intend this consent to apply to all my present and future massages.

NAME: _____ SIGNATURE:_____
Please Print

Date_____

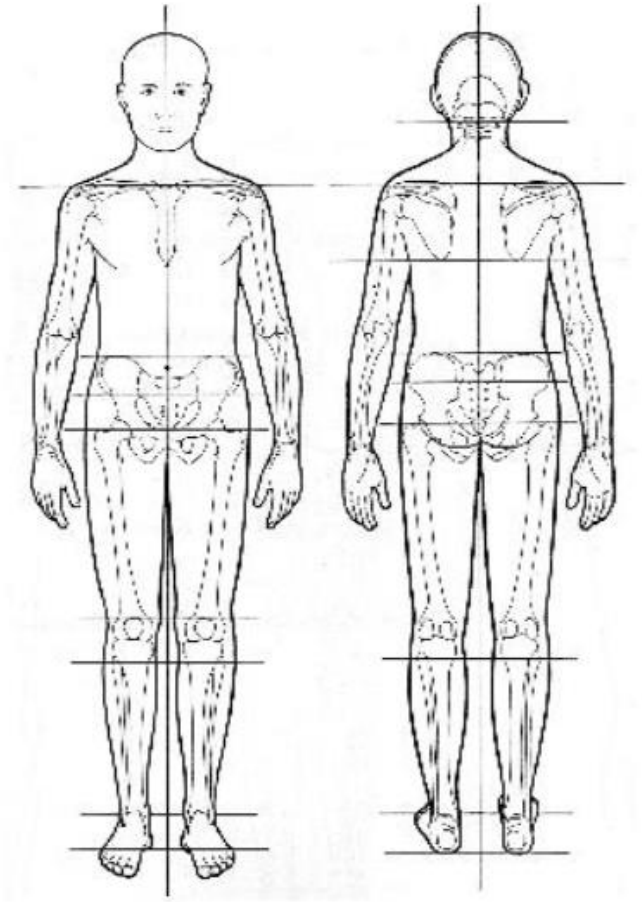
PAIN AND DISCOMFORT DIAGRAM

YOUR NAME:_____

DATE:_____

Please indicate painful areas on the diagram using the symbols

Burning = xxxxxx
Numbness= ……. Aching = ******
Pins and Needles = ooooo Stabbing = ///////



In your own words, please describe your pain:

_____

_____

_____

Does this pain interfere with your work/daily activities?_____

_____

Have you seen your Dr. about this discomfort/pain?_____

Is this the result of an injury? Y ☐ N ☐

If YES- Date_____ Injury type_____

Have you ever been in a car accident?_____

If YES- Date_____Injury type_____

Current Medications	**Surgeries**	**Any Internal pins/wires/artificial joints/special equipment?**
What: For Treatment of:	What: Date:	What: Where:
What: For Treatment of:	What: Date:	What: Where:
What: For Treatment of:	What: Date:	What: Where:
What: For Treatment of:	What: Date:	What: Where:

Please indicate which condition you **are** currently, or **have previously experienced**

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart Attack
- ☐ Phlebitis / varicose veins
- ☐ Stroke
- ☐ Pacemaker/similar device
- ☐ Heart disease

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

Infections
- ☐ Hepatitis Type: ____
- ☐ Skin Condition: Type _____
- ☐ Tuberculosis
- ☐ HIV/AIDS
- ☐ Herpes
- ☐ Other:_____

Other Conditions
- ☐ Loss of sensation: Where:_____
- ☐ Allergies: Type:_____ Type of reaction:_____
- ☐ Diabetes: TYPE:_____
- ☐ Cancer: TYPE: _____
- ☐ Arthritis
- ☐ Epilepsy

Women
- ☐ Pregnant: Due Date: _____
- ☐ Gynecological Conditions:_____
- ☐ Other:_____

Gastrointestinal
- ☐ Diarrhea
- ☐ Constipation
- ☐ Heartburn
- ☐ Celiac Disease
- ☐ Crohn's Disease
- ☐ Other:_____

- ☐ Any Family History of the above?

Please list: _____
_____

Please indicate which condition you **are** currently, or **have previously experienced**

Soft Tissue/Joint Pain
- ☐ Neck
- ☐ Upper back/Shoulders
- ☐ Arms/Hands
- ☐ Mid-back
- ☐ Low Back
- ☐ Hips
- ☐ Legs
- ☐ Knees/Feet

Head/Neck
- ☐ Headaches/Migraines Frequency:_____
- ☐ Vision problems/Loss
- ☐ Ear problems
- ☐ Hearing loss
- ☐ Other: _____
- ☐ Any family history of the above: _____

CLINIC USE ONLY

Update 1:_____ Details of Update:_____ INITIAL _____

Update 2:_____ Details of Update:_____ INITIAL _____

Update 3:_____ Details of Update:_____ INITIAL _____