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.): _______________________

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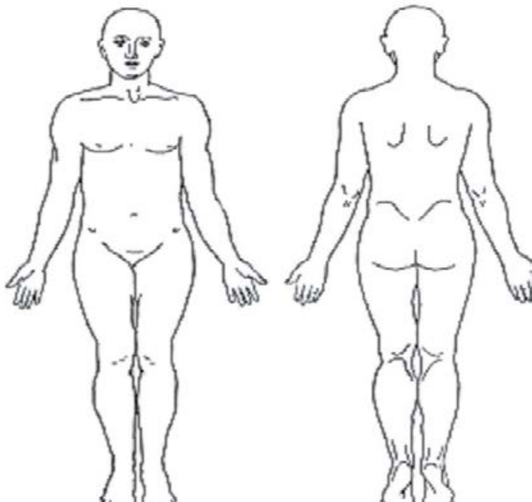
Other medical professionals you are currently being treated by (chiropractor, physiotherapist, etc.):

____

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: ________________________