Oakville MASSAGE & WELLNESS Clinic

77 John St, Suite #201 | Oakville, ON | L6K 3W3

Personal Information

Patient Name: _____ Date of Birth: ____yyyy____ / __mm__ / __dd__ Age: _____

Address: _____ City:_____ Prov: _____ Postal Code: ____ ____

Email Address: _____@_____ . _____ Sex: M☐ F☐

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Work Phone: (_____) _____-_____ Occupation: _____

Check One: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced # of Children: _____

Who can we thank for referring you to OMWC? _____

Current Health

Main/Current Health Concern(s): _____

Other Doctors/Specialists/Therapists seen for this concern? Y☐ N☐ Who?: _____

Type of Treatment(s): _____ Results: _____

When did this begin? _____ Have you had this before? Y☐ N☐

What makes this worse? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking
☐ Lying Down ☐ Cold ☐ Hot ☐ Dampness ☐ Other: _____

What makes this better? ☐ Rest ☐ Ice ☐ Heat ☐ Massage ☐ Walking
☐ Medication(s) _____ ☐ Other: _____

Character of Discomfort: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins-Needles ☐ Numb
☐ Constant ☐ Intermittent Pain ☐ Burning ☐ Other: _____

What else have you ever tried to get rid of this? _____

Circle the number on the scale to indicate the severity of your discomfort (if applicable):

LEAST (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) *WORST*

Medications you take now: ☐ Painkillers/Muscle Relaxants ☐ Insulin ☐ Blood Pressure Medication
☐ Other: _____

On a scale of 1-10, 10 being the highest, rate your commitment to helping us solve this: _____

Past Health History

Major Surgery / Operations: _____

Previous: ☐ Childhood Traumas _____ ☐ Motor Vehicle Accidents: _____
☐ Sports Injuries: _____ ☐ Work Injuries: _____
☐ Hospitalization (other than above): _____

Family Health History

Name of Family Physician: _____

Please indicate any health issues that are present in your family: Parents: _____ Siblings: _____
Do any members of your family suffer from the same condition (as you)? ☐ N ☐ Y Who? ____

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Below is a list of symptoms or diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Check any of the following you have had in the past 6 months, even if they do not seem related to your current problem:

Nervous System
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion / Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold / Tingling Extremities
- ☐ Stress

Musculo-Skeletal
- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Heartburn
- ☐ Neck Pain

Irregularity
- ☐ Arm Pain

Cramping
- ☐ Joint Pain / Stiffness
- ☐ Walking Problems
- ☐ Difficulty Chewing / Clicking Jaw
- ☐ General Stiffness

Satisfaction with Diet
- ☐ Highly Satisfied
- ☐ Satisfied
- ☐ Dissatisfied
- ☐ Highly Dissatisfied

Intake
- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ White Sugar
- ☐ Cigarettes

Do you have a regular Exercise program?
- ☐ Y ☐ N ☐

How often do you exercise?
- ☐ 1-2 times per week
- ☐ 2-4 times per week
- ☐ >4 times per week

Sleeping Position
- ☐ Stomach
- ☐ Side
- ☐ Back

General
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Headaches

C-V-R
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

Lifestyle Stress Levels
- ☐ High
- ☐ Moderate
- ☐ Very Little
- ☐ None

Check any of the following diseases you have had:
- ☐ Pneumonia
- ☐ Mumps
- ☐ Influenza
- ☐ Polio
- ☐ Chicken Pox
- ☐ Arthritis
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Cancer
- ☐ Mental Disorder
- ☐ Anemia
- ☐ Heart Disease
- ☐ Measles
- ☐ Thyroid
- ☐ Psoriasis
- ☐ Eczema

Gastro-Intestinal
- ☐ Black / Bloody Stool
- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Abdominal Cramps
- ☐ Gas / Bloating After Meals
- ☐ Colitis

Male / Female
- ☐ Menstrual
- ☐ Vaginal Pain Infections
- ☐ Breast Pain / Lumps
- ☐ Prostate / Sexual
- ☐ Dysfunction

Female

When was your last period?

_____

Are you pregnant?

☐ N ☐ Y ☐ Not Sure

Genito-Urinary
- ☐ Bladder Trouble
- ☐ Painful / Excessive Urination
- ☐ Discoloured Urine

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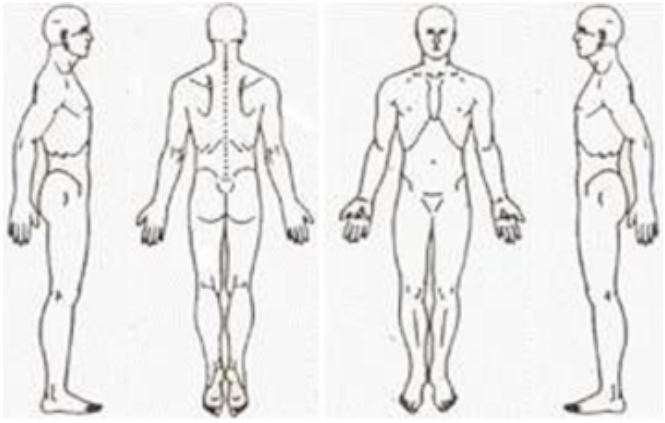
Pain Diagram
Please outline the area of discomfort below:

Pain - xxxx
Stiffness - ///////
Numbness - oooo



Informed Consent for Chiropractic Treatment

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a. While rare, some patients may experience short-term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c. There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the content of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

Signature: _____ Signature: _____
Patient (Legal Guardian) Witness

Name: _____ Name: _____

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Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture and, as needed, other procedures by Dr Adam C. Dunn.

I understand that in the practice of acupuncture, there are some risks including, but not limited to minor bleeding/bruising, minor soreness, nausea, fainting, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles are used, which are disposed of after each use/treatment.

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on Dr. A. Dunn to exercise judgment during the course of treatment, which based on the facts then known, is in my best interest. I understand that the results are not guaranteed.

I have read the above consent form. I have had an opportunity to ask questions, and by signing below, I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future considerations and extend this consent to the acupuncture colleagues within this clinic.

NOTE to Female Patients:
I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible.

_____ I hereby state that I am NOT pregnant nor is there any possibility that I may be pregnant. I also understand it is my responsibility to inform the doctor prior to treatment if I become pregnant in the future.

_____ I hereby state that I AM pregnant. I also understand it is my responsibility to inform the doctor prior to treatment if I become pregnant again in the future.

Dated this _____ day of _____, 20_____.

Signature: _____ Signature: _____
Patient (Legal Guardian) Witness

Name: _____ Name: _____
(please print) (please print)