

Healthquest Chiropractic & Natural Medicine
301, 1228 Kensington Rd NW, Calgary AB T2N 3P7
Phone: 403-270-0604 Fax: 403-270-0634

New Patient Intake Form

Name _____ Biological Sex: Male Female
Identifying Gender: Male Female Other Pronoun: he/him she/her they/them other
Address _____ Postal Code _____
Home Phone Number _____ Work _____ Mobile _____
Emergency Contact Name/Number _____
Date of Birth _____ Alberta Health Number _____
Email Address _____ Would you like an email reminder? Yes No
Current Medical Physician _____
Name of Clinic _____ Phone Number _____
Occupation _____ Is this a work-related injury? _____

Collection of Personal Health Information

At Healthquest we collect from our patients basic contact information and medical information including health history, physical conditions and treatment notes. Medical information is used to properly diagnose and insure we provide safe treatments to our patients. Healthquest utilizes an Electronic Health Record system to store medical information.

All personal and health information is collected as authorized by the Health Information Act under Section 20.

If you have a concern about your personal information, please feel free to discuss these concerns with Dr. Miranda Moen directly.

Dr. Miranda Moen
Privacy Officer
Healthquest Chiropractic & Natural Medicine Ltd
301, 1228 Kensington Road NW
Calgary, AB T2N 3P7
drmoen@healthquestcalgary.com

Massage Therapy Intake Form

**It is the policy of Healthquest that payment be made at the time of service. Receipts are provided for the patient to arrange reimbursement from your extended insurance policy if applicable.

Past Health History (please include description and date)

Surgeries/operations: _____

Accidents or falls: _____

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

Musculoskeletal	Skin	Genito-urinary	
Bone or joint diseases	Dryness	Pregnant (how many months)	
Tendonitis	Bruise easily	PMS	
Bursitis	Allergies	Menopause	
Broken/fractured bones	Rashes	Frequent urination	
Arthritis	Athletes foot	Kidney infection	
Sprains/strains	Warts	Painful urination	
Low back, hip, leg pain	Other:	Prostate trouble	
Neck, shoulder, arm pain	Digestive	Other:	
Headaches/head injuries	Constipation	Other	
Spasms/cramps	Diarrhea	Cancer/tumors	
Jaw pain/TMJ	Gas/bloating	Diabetes	
Flat feet/high arches	Diverticulitis	Mental health conditions	
Other:	Irritable bowel syndrome	Poor nutrition	
Circulatory	Other:	Drug/alcohol consumption	
Heart condition	Nervous system	Nicotine	
Varicose veins	Numbness/tingling	Caffeine	
Blood clots	Chronic pain	Other:	
High blood pressure	Herpes/shingles	Infectious diseases (name below)	
Low blood pressure	Fatigue		
Lymphedema	Sleep disorders		
Other:	Other:		
Respiratory			
Chest pain			
Chronic cough			
Difficulty breathing			
Asthma			
Allergies			
Ear aches			

Massage History/Treatment Information:

Have you received a professional massage? Yes No If yes, date of last massage: _____

What results do you want from your massage session? _____

Current Concern: _____

Describe the onset: _____

Rate symptoms: Mild, Moderate, or Severe

Are you currently being treated by anyone else for your complaint? If Yes with who?

List medications, including aspirin, ibuprofen, antihistamines, birth control, etc.

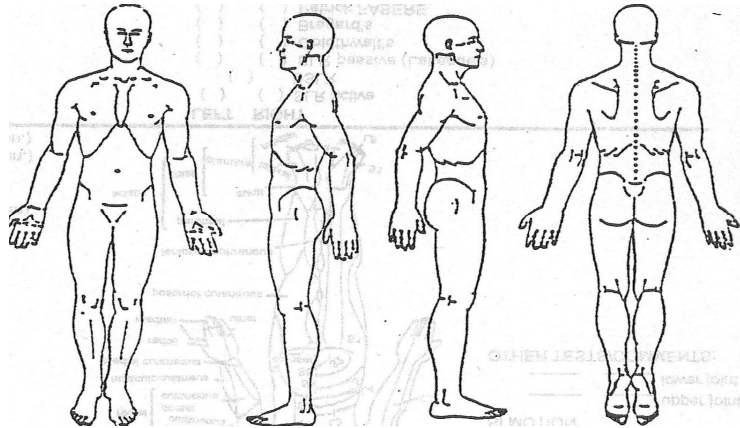
On the diagram please indicate areas where you are experiencing pain or unusual feeling.

Legend:

Pain = X

Numbness = O

Stiffness = //



Please read the following:

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 or energy flow.

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

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

Date: _____ Signature: _____

Name (Please Print): _____