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 _____ Gender: M / F Biological Sex: M / F

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.

_____

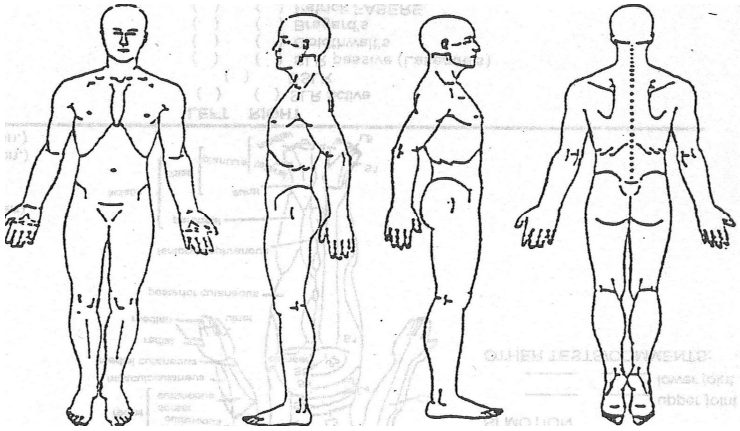
_____

_____

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): _____