HOLLY CHIROPRACTIC & Wellness

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Barrie, ON
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barriechiropractor.ca

Massage Therapy Rates of Service:
30 minute massage- $75 45 minute massage- $95
60 minute massage- $110 90 minute massage- $160 **Date:**_____

Name: _____Age: _____
Address: _____Home Phone#: (__) _____
Cell Phone #: (__) _____Date of Birth: _____
City: _____Province: _____Postal Code: _____
E-Mail Address: _____
May we have your permission to contact you via email?: (circle one) YES NO
Occupation: _____
Employer: _____Work Phone #: (__) _____
How did you hear about our clinic? _____

Health History: Please indicate conditions you are experiencing, or have experienced:

Respiratory:
__chronic cough
__shortness of breath
__bronchitis
__asthma
__emphysema
__family history of the above?

Cardiovascular:
__high blood pressure
__low blood pressure
__CHF
__heart attack
__phlebitis
__stroke/ CVA
__pacemaker or similar device
__heart disease

Skin:
__ skin conditions/sensitivities
__List:_____

Women
__Pregnant? Due Date_____

Other Conditions:
__loss of sensation
__diabetes? Type & onset:_____
__arthritis
__family history of arthritis
__epilepsy
__cancer
__allergies? List:_____
__fibromyalgia

Head/ Sensory:
__vision problems
__vision loss
__ear problems
__hearing loss
__headaches or __ migraine

Infections:
__hepatitis
__skin
__TB
__HIV
__Other:_____

Soft tissue/ joint discomfort & its nature (ie: ache/ pains/ sprain):
__head/neck_____
__shoulders/arms_____
__upper back _____
__middle back _____
__low back _____
__hips/legs _____
__knee s_____
__feet/ ankle _____
__other _____
__car accidents?
when? _____

Other Medical Conditions (eg: digestive concerns, gynecological conditions, hemophilia, etc.)_____
_____

Of Special Note: (artificial joints, internal pins, wires, special equipment):_____
_____

Are you receiving any other treatment? (ie: chiropractic, naturopath?) ___yes, ___no, Please specify_____

How is your overall health? _____
Current Medication(s) _____Condition it treats_____
Surgeries_____Injuries_____
Family Physician_____ Phone #:_____
May we contact your Physician with regard to your massage treatment? YES NO

PAIN ASSESSMENT

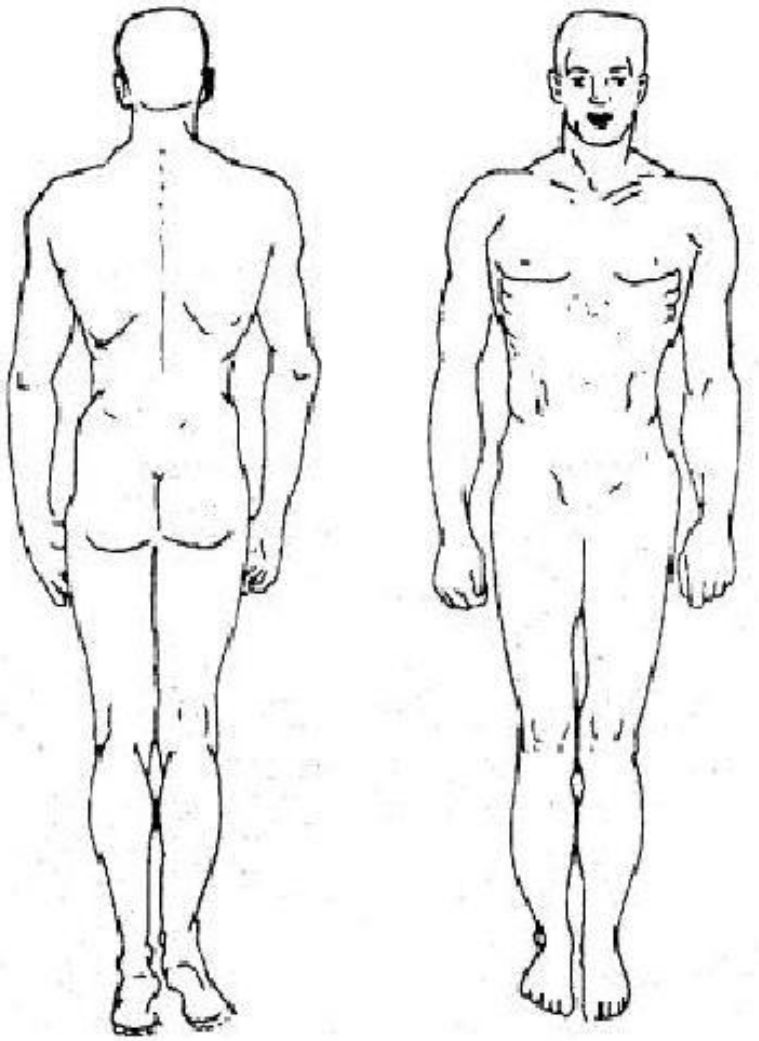
Patient Name_____ Date_____

Using the diagrams below, please indicate the areas in which you are experiencing symptoms. Please indicate the type of pain/ discomfort using the appropriate symbols, and including all affected areas.

Dull Aching: XXX
XXX

Sharp Pain ///////
///////

Burning \\\\\\\\\
\\\\\\\\\

Numbness +++
+++

Pins & Needles **ooo**
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