Chiro-Santé Kirkland Clinic

Opening File (Massage)

Name: ______________________

Gender: ________ Date of Birth: ______________

Occupation: ______________________

Address: ______________________

City: ______________________

Province: ____________ Postal Code: ____________

E-mail address: ______________________

Home Phone: ____________ Cell Phone: ____________

1) Have you seen a doctor recently? Yes: ❑ No: ❑ Date: ______________

2) Do you suffer from diabetes? Yes: ❑ No: ❑

3) Do you suffer from cardiovascular problems? Yes: ❑ No: ❑

4) Are you treated for blood pressure? Yes: ❑ No: ❑

5) Do you suffer from allergies? Yes: ❑ No: ❑ if yes, what: Herbs: ❑ Iodine: ❑ Certain Foods: ❑ Skin Allergies: ❑

if yes, explain: ______________________

6) Do you suffer problems with elimination? Yes: ❑ No: ❑ if yes, what: Urine: ❑ Stool: ❑ Water Retention: ❑

7) Are you pregnant? Yes: ❑ No: ❑ Breastfeeding? Yes: ❑ No: ❑ Menopause: ❑ Cesarian: ❑

8) Have you had an operation recently? Yes: ❑ No: ❑ if yes, date: ______________________

9) Have you ever received injections for? Cellulitis: ❑ Phlebitis: ❑ Varicose Veins: ❑

10) Do you suffer from bad circulation? Yes: ❑ No: ❑

11) Health Problems Liver: ❑ Kidneys: ❑ Lungs: ❑ Epilepsy: ❑ Nerves: ❑ Other: ❑

if yes, explain: ______________________

12) Are you currently under medication? Yes: ❑ No: ❑ if yes, explain: ______________________

13) Do you suffer from a skin ailment? Psoriasis: ❑ Eczema: ❑ Acne: ❑ Other: ❑

if yes, explain: ______________________

14) Is your hunger exaggerated? Yes: ❑ No: ❑

15) Are you presently following a diet? Yes: ❑ No: ❑