

**Bridlewood Chiropractic Clinic – Confidential Health History**  
**Lynette Ridgeway, RMT**

Name		Date (MM/DD/YR)	
Street Address		City	Postal Code
Phone (day)	Phone (evening)	Occupation	
Date of Birth (MM/DD/YR)	Circle if loss of Hearing   Sight   Sensation	Referred by	
Physician	Physician's Phone	Physician's Address	Consent to contact Physician Yes   No   Signature
Primary Complaint			

**Past and/or Present Conditions - Circle F if Condition is Present in Family**

<b>HEART</b> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Chronic congestive Heart Failure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Phlebitis <input type="checkbox"/> History of Cardiovascular Accidents <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Attack <input type="checkbox"/> Pacemaker or Similar Device <input type="checkbox"/> Other <hr/> <b>INFECTIOUS DISEASE</b> <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Hepatitis <input type="checkbox"/> Infectious Skin Conditions <input type="checkbox"/> HIV+ <input type="checkbox"/> AIDS <input type="checkbox"/> Other <hr/>	<b>SYSTEMIC</b> <input type="checkbox"/> Cancer <input type="checkbox"/> Epilepsy <input type="checkbox"/> Allergies <input type="checkbox"/> Skin Growth or Tumour <input type="checkbox"/> Diabetes: Type I or Type II <input type="checkbox"/> Arthritis: Type _____ <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Hypoglycemic <input type="checkbox"/> Hemophilia <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Lupus <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> Skin Conditions <hr/> Digestive Conditions <hr/> Other <hr/>	<b>GENERAL</b> <input type="checkbox"/> Chest Pain Menstrual Pain Abdominal Pain Fatigue Artificial Joints/Pins Anorexia Bulimia Contact Lens Special Equipment Insomnia Bruise Easily Other <hr/> <b>ALLERGIES</b> Sensitivities to Oils, Lubricants Sensitivities to Latex Other <hr/>	<b>RESPIRATORY</b> Asthma Emphysema Bronchitis Shortness of Breath Chronic Cough Other <hr/> <b>ADDITIONAL</b> Pregnancy - Due Date: _____ <hr/> Psychological Health Issues <hr/>
--	--	--	---

Other Diagnosed Medical Issues: \_\_\_\_\_  
 Medications and Side Effects: \_\_\_\_\_  
 Past or Present Injury and Surgery: \_\_\_\_\_

During the course of the massage, you may wear as little or as much clothing as you feel comfortable, however massage is most effective if performed directly on the skin. Your Therapist is trained to drape sheets and towels discreetly over all areas of your body not involved in the treatment, protecting your privacy at all times.

Potential benefits of massage include decrease pain, increase circulation, increase comfort, and increase range of motion. At any time you may ask the Therapist to adjust their pressure. Though some techniques may be temporarily uncomfortable, they are used to reduce your symptoms. Your overall comfort is of utmost importance. There is a slight chance that your symptoms may temporarily increase. Various forms of hydrotherapy may be used to encourage the healing process.

You may ask questions at any time. Does your Therapist have consent for treatment?  
 Yes.

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date