Registered Massage Therapy Health Questionnaire

santē | chiropractic wellness

Date:_____/_____

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or requested by law. Your written permission will be required to release any information.

Last Name:_____First Name: _____

Address:_____Town:_____Postal Code: _____

Date of Birth: *Day*_____*Month*_____*Year* _____ Occupation: _____

Home Phone #: _____ Work Phone #: _____

Have you received massage therapy before? YES NO

Did a health care practitioner refer you for a massage therapy? YES NO

If yes, please provide their name and address: _____

_____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular

□High blood pressure □Low blood pressure □Chronic congestive heart failure □Heart attack
□Phlebitis □Stroke/CVA □Pacemaker or similar device □Heart disease □Phlebitis/Varicose veins

Is there a family history of any of the above? YES NO

Respiratory

□Chronic cough □Shortness of breath □Bronchitis □Asthma □Emphysema

Is there a family history of any of the above? YES NO

Infections

□Hepatitis □Skin conditions □TB □HIV □Herpes

Other Conditions

Loss of sensation Where? _____

Diabetes, onset: _____

Allergies/Hypersensitivity To what?_____ Type of reaction? _____

Epilepsy: YES NO Cancer: YES NO Skin Condition(s): YES NO What? _____

Arthritis Is there a family history of Arthritis? YES NO

Head/Neck

□History of headaches □History of migraines □Vision problems □Vision loss □Ear problems □Hearing loss

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Women

Pregnant? YES NO Due date: _____

Gynecological conditions? YES NO

If yes, what? _____

Overall, how is your general health?

Primary care Physician & address: _____

Current medications and conditions it treats:

_____

_____

Are you currently receiving treatment from another health care professional: YES NO

If yes, for what? _____

Surgeries

Date: _____ Nature: _____

Date: _____ Nature: _____

Injuries

Date: _____ Nature: _____

Date: _____ Nature: _____

Do you have any other medical conditions? (E.g. digestive conditions, hemophilia, osteoporosis, mental illness)

YES NO

What? _____

Do you have any internal pins, wires, artificial joints or special equipment? YES NO

What? _____

Where? _____

What is the reason you are seeking massage therapy?

□Stress Relief □Prevention/Maintenance □Problem Correction

_____

_____

Registered Massage Therapy Payment & Cancellation Policy

Payment is due at the time of your appointment. Please note that registered massage therapy is not covered by OHIP. However, many private health insurance plans do include coverage for registered massage therapy services. We recommend checking with your insurance provider to confirm your specific coverage details and whether a referral from a medical doctor is required for reimbursement.

If you need to cancel or reschedule your appointment, we kindly ask for a least 2 hours' notice. Cancelation made with less **than 12 hours' notice,** or missed appointments, will be subject to a **$75.00 cancelation fee.**

We appreciate your understanding and look forward to supporting your unique health and wellness needs and goals.