ST MARGARET'S BAY
Chiropractic Centre
BODY • FAMILY • LIFE

Massage Therapy – Office Info

☐ *Doctor*	☐ *Patient Signature*
☐ *Category*	☐ *RMT#1 Signature*
☐ *Info Entered*	☐ *RMT#2 Signature*
☐ *Referred By*	☐ *Thank-You Card*

New Client Questionnaire **(Please Print)**

In order to help us evaluate you thoroughly, please complete the following form. This information is important in order that we provide you with safe and effective treatment. Please be as accurate as possible

Name:_____ Date of Birth (d/m/y): _____ Gender: ☐ M ☐ F

Address: _____

City: _____ Postal Code:_____

If you have a separate mailing address from your civic address please indicate it here:

_____

Home Phone: _____

Cell Phone:_____ Preferred Phone: Cell ☐ Home☐

Email Address: _____

Occupation: _____ Business Telephone: _____

Emergency Contact:_____ Phone:_____

Referred to this office by: Medical Doctor☐ Chiropractor☐ Physiotherapist☐ Other Massage Therapist☐
Friend☐ Family Member☐ Yellow Pages☐ Website☐ Other_____

Current Health Condition

Area of Main Concern: _____

_____

When did this begin? _____

Is it getting: ☐Better ☐Worse ☐Staying the Same

How often does this happen? ☐This is the First Time ☐Constant ☐Comes and Goes ☐Occasional

Has this happened before? ☐Yes ☐No If Yes, When? _____

Did you receive treatment? ☐Yes ☐No If Yes, Where and When? _____

What does this feel like? (check any that apply) ☐Sharp ☐Dull ☐Travels ☐Radiating ☐Throbbing ☐Achy
☐Shooting ☐Tingly/Numb ☐Cramping ☐Pinching ☐Pulling ☐Stiff/Tight

What aggravates your problem? _____

What makes it feel better? _____

Your Medical Doctor's Name and Location of Practice: _____

Are you currently receiving any other form of health care for this or any other issue? ☐Yes ☐No

_____

There are some health conditions which require modification of your massage therapy treatment. Please check all symptoms/conditions you have ever had, even if they do not seem related to your current problem:

☐ Asthma	☐ Antherosclerosis	☐ Kidney Disease	☐ Allergies
☐ Diabetes	☐ Rheumatoid Arthritis	☐ Aneurysm	☐ Lymphedema
☐ Hemophilia	☐ Deep Vein Thrombosis	☐ Osteoporosis	☐ Migraine
☐ Cancer	☐ Varicosities	☐ Seizure Disorder	☐ Constipation
☐ Lupus	☐ Multiple Sclerosis	☐ Disc Herniation	☐ Hernia
☐ Bursitis	☐ Low Blood Pressure	☐ Frozen Shoulder	☐ Fibromyalgia
☐ TMJ	☐ High Blood Pressure	☐ Irritable Bowel	☐ Osteoarthritis

List any Medications or Vitamin Supplements you presently take: _____

_____

_____

For Females Only : Are you pregnant? Yes ☐ No ☐ If Yes, how many weeks are you currently? _____

Past Health History (This will help give a more complete picture of your current health)

List any surgery, accidents and falls, including year: _____

_____

_____

Have you ever had Massage Therapy treatment? Yes ☐ No ☐

If Yes, When? _____ Where? _____

For what reason? _____

Have you had X-rays taken? Yes ☐ No ☐

Do you wear orthotics? Yes ☐ No ☐

Do you have any surgical implants/pins/plates? Yes ☐ No ☐

Do you use any other orthopedic device/aid? Yes ☐ No ☐

How much of the following do you consume daily?

Cups of Coffee _____ Cigarettes _____

Cups of Tea Alcoholic

Do you skip meals? ☐ Occasionally ☐ Frequently

Do you exercise? ☐ Yes ☐ No Amount per week? _____

I _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, and prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. Person's aged 16 years or younger require signed consent from a parent or legal guardian in order to receive therapeutic massage.

***24 hour notice is required to cancel or reschedule a massage therapy appointment. Late cancellations will be subject to a cancellation fee of $ 25.00.**

Signature of Client/Guardian: _____Date:_____

Signature of RMT: _____Date:_____

Signature of RMT: _____Date:_____