Registered Massage Therapy

File #: _____

Date: _____

Waterdown Village Chiropractic & Wellness Group

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Unit #14A
Waterdown, ON L8B 0E5
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# General Information

**How do you wish to be addressed in our office?**

☐ First name ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

**How do you wish to be contacted by our office regarding your appointments?**

☐ Email ☐ Phone

**Last Name:** _____ **D.O.B.** _____

**First Name:** _____ **Sex:** ☐ M ☐ F

**Address:** _____

**Town/City:** _____ **Province:** _____ **Postal Code:** _____

**Home Phone: (  )** _____ **Cell Phone: (  )** _____

**Email:** _____ _____ **Consent to receive email communication from the clinic**
Please Initial

**Occupation:** _____ **Spouse's name (if applicable):** _____

**Children:** Y N **Number:** _____ **Ages:** _____

**(Females) Are you pregnant?** Y N **How many weeks?** _____ **Estimated Due Date:** _____

**Family Dr. Name:** _____ **Phone: (  )** _____

**Previous Wellness Care?** (check all that apply)

☐ Chiropractic ☐ Physiotherapy ☐ Naturopathy ☐ Massage Therapy ☐ Osteopathy

**Location:** _____

**Referred by:** _____

**How did you decide to choose our office?** _____

**Reason for consulting the office:**

- ☐ I have a specific problem and require help only with this problem.
- ☐ After my specific problem has been relieved, I am interested in strategies for maintenance.
- ☐ After my specific problem has been resolved and I understand methods to ensure it does not return, I am interested in strategies to improve my general health.
- ☐ I have no symptoms and I feel well. I am interested in strategies to help me to continue to feel well, or even better.

**Personal Information and Privacy Policy:**

*All personal information remains protected and confidential and will not be released without your previous written consent. I may view the Waterdown Village Chiropractic Group privacy policy in full at any time.* File #: _____

## HEALTH HISTORY: (please check all that apply)

**Musculoskeletal**
- ☐ Bone or joint disease
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Fractures
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Sprains/strains
- ☐ Low back/hip/leg pain
- ☐ Neck/shoulder/arm pain
- ☐ Headaches/head injuries
- ☐ Migraines
- ☐ Jaw pain/TMJ Syndrome
- ☐ Spasms/cramps
- ☐ Other: _____

**Skin**
- ☐ Allergies/skin irritation
- ☐ Rashes/infections
- ☐ Athletes' Foot
- ☐ Warts
- ☐ Other: _____

**Infectious Disease**
- ☐ Hepatitis (Type: _____)
- ☐ TB
- ☐ HIV
- ☐ Other: _____

**Circulatory**
- ☐ Heart disease
- ☐ Varicose veins
- ☐ Blood clots
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Lymphedema
- ☐ Breathing difficulty
- ☐ Sinus problems
- ☐ Allergies
- ☐ Anaphylaxis
- ☐ Chronic congestive heart failure
- ☐ Myocardial infarction
- ☐ Stroke
- ☐ Phlebitis
- ☐ Hemophilia
- ☐ Pacemaker
- ☐ Other: _____

**Nervous System**
- ☐ Herpes/shingles
- ☐ Numb/tingling
- ☐ Loss of sensation
- ☐ Chronic pain
- ☐ Fatigue
- ☐ Sleep disorder

**Digestive**
- ☐ Constipation
- ☐ Gas/bloating
- ☐ Diverticulitis
- ☐ Irritable Bowel Syndrome
- ☐ Chron's/Colitis
- ☐ Other: _____

**Respiratory**
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Asthma
- ☐ Other: _____

**Other**
- ☐ Cancer
- ☐ Depression
- ☐ Drug/alcohol addiction
- ☐ Nicotine/caffeine addiction
- ☐ Diabetes (type: _____)
- ☐ Hearing loss
- ☐ CFS/Fibromyalgia
- ☐ Allergies to oils
- ☐ Other: _____

**Current Medications:** _____

**Surgeries (please list and date):** _____

**Injuries/Accidents still affecting daily activities (please list):** _____

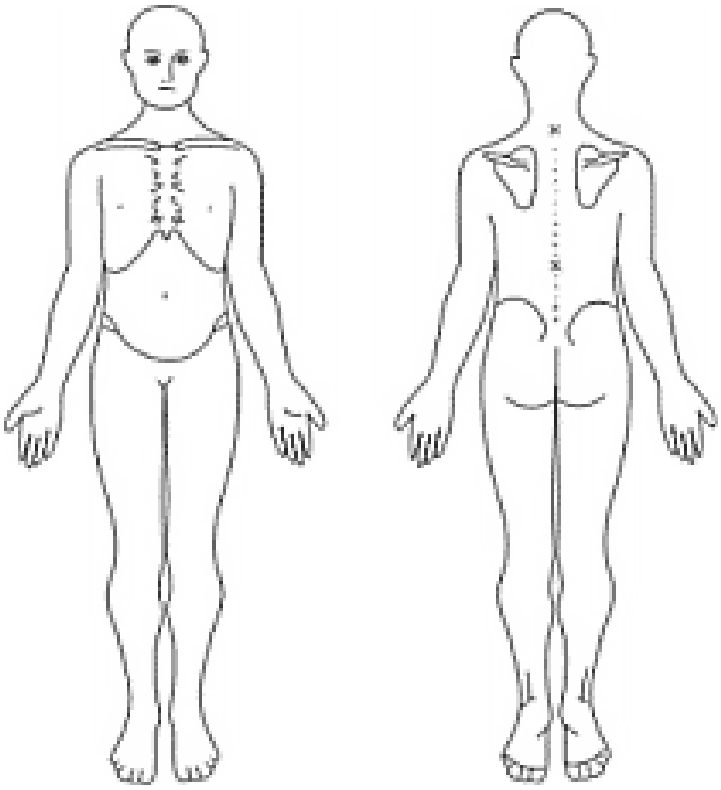
_____

**Do you have any internal pins, wires, artificial joints or special equipment?** Y N

**General Health Status (please circle one):** POOR AVERAGE GOOD EXCELLENT

File #: _____

**Please indicate with an 'X' any areas on the figure where you are experiencing pain. Please shade any areas you experience tension or discomfort.**



**Consent**

It is my choice to receive massage therapy. I am aware that an assessment may be necessary. Removal of all articles of clothing is not required for treatment, and I will remove only the clothing I am comfortable with. I am aware that I may experience side effects such as temporary discomfort within the muscles, bruising or temporary dizziness. I understand that I may alter or terminate my treatment at any point.

## Cancellation Policy

**While the clinic does provide regular appointment reminders, I acknowledge that I am responsible for my attendance and that 24 hours' notice is required should I wish to cancel or reschedule my appointment. If less than 24 hours' notice is given, or If I fail to show for my scheduled appointment, I understand that one of the following charges will be applied to my account:**

- **A cancellation fee of $25.00 should I cancel an appointment with less than 24 hours' notice**
- **A full appointment fee should I not show for my scheduled appointment without notice**

**Please initial to confirm that you have read the cancellation policy and agree to pay any outstanding balances owing. _____ (Initial Here)**

**Name:** _____

**Signature:** _____ **Date:** _____
(18 years of age or older)

**Parental/Guardian Signature:** _____ **Date:** _____