HALTON Chiropractic AND WELLNESS CLINIC

250 Wyecroft Road, Suite #5
Oakville, ON L6K 3T7
Tel: 905.844.9117
Fax: 905.844.9118
www.haltonchiropractic.ca

REGISTERED MASSAGE THERAPY

NEW PATIENT QUESTIONNAIRE

Name: _____ Date: _____
(Last) (First)

Address: _____
(Street) (City)

_____
(Province) (Postal Code)

Phone: Home (____)_____ Work (____)_____ Cell (____)_____

E-mail Address: _____

Date of birth: _____ Age: _____ Height: _____
(Day / Month / Year)

Birth Place: _____ Weight: _____

Gender: M or F (Please Circle) # of children: _____

Emergency Contact: _____ _____ (___)_____
(Name) (Relationship) (Phone)

Family physician: _____ Referred by: _____

Occupation: _____

Employer's Name: _____

Employer's Address: _____

What brings you in for a massage treatment? _____

Have you had any previous treatment for this condition? If so when? _____

HEALTH HISTORY

Please check any conditions you are currently experiencing or have experienced in the past.

P= Previous Ailment C= Current Ailment

P C HEAD & NECK
□ □ Vision problems
□ □ Eyeglasses/cont. lenses
□ □ Earaches
□ □ Sinus

P C RESPIRATORY
□ □ Chronic cough
□ □ Smoking
□ □ Shortness of breath
□ □ Breathing problems
Explain: _____

P C CARDIOVASCULAR
□ □ High blood pressure
□ □ Low blood pressure
□ □ Poor circulation
□ □ Heart disease
□ □ Phlebitis
□ □ Stroke
□ □ Varicose Veins
Dr. Diagnosed? Y/N

P C OTHER
□ □ Digestion difficulty
□ □ Constipation
□ □ Liver
□ □ Kidney
□ □ Bladder
□ □ Gallbladder
□ □ Diabetes, Type __
□ □ Insomnia
□ □ Epilepsy
□ □ Cancer
□ □ Arthritis
Doctor diagnosed: Yes/No

P C JOINT/MUSCLE PAIN
□ □ Neck
□ □ Shoulder L/R
□ □ Upper Back
□ □ Mid Back
□ □ Low Back
□ □ Hip L/R
□ □ Leg L/R
□ □ Knee L/R
□ □ Foot L/R
Any previous dislocations? Y/N

P C WOMEN ONLY
Are You Pregnant? Yes No
□ □ Menstruation problems
□ □ Breast discomfort
□ □ Caesarian section
□ □ Gynecological surgery
Date: _____
# of Pregnancies_____
# of Children_____

P C INFECTIONS
□ □ Herpes
□ □ Hepatitis
□ □ Tuberculosis
□ □ HIV/AIDS
Other: _____

P C SKIN
□ □ Loss of sensation
□ □ Bruise easily
□ □ Allergies
□ □ Skin conditions
What? _____

CURRENT MEDICATIONS:

Medication	Condition
_____	_____
_____	_____
_____	_____

SURGERY:
Type: _____
Date: _____
Details: _____

INJURY (SPRAINS, FRACTURES, ETC):
Type: _____
Date: _____
Details _____

MEDICAL CONCERNS

Please check if you have/use any of the following*:*

- ☐ Wires
- ☐ Plates
- ☐ Artificial limbs
- ☐ Artificial joints

  If yes, where?

  _____

- ☐ Wheelchair
- ☐ Walker
- ☐ Cane
- ☐ Brace
- ☐ Pacemaker

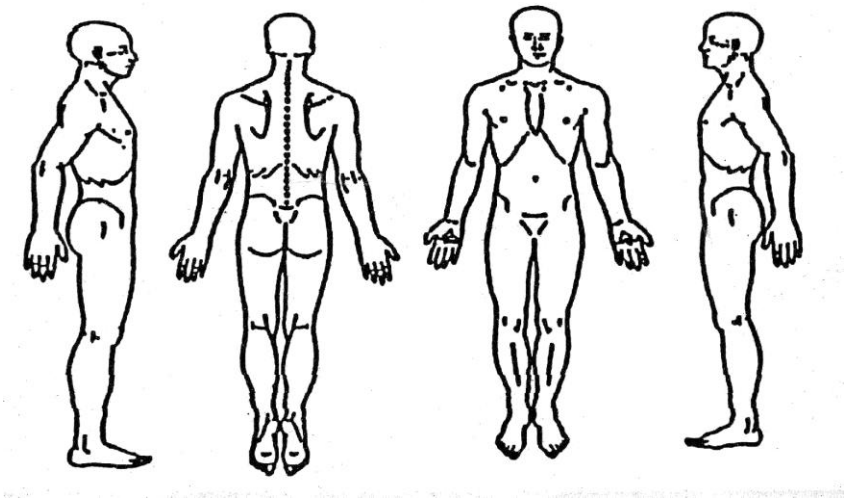
  Please specify if applicable:

  _____

OTHER HEALTH CARE: P= Previous C= Current

P	C		P	C		P	C	
☐	☐	Chiropractor	☐	☐	Physiotherapy	☐	☐	Regular Exercise
☐	☐	Massage Therapy	☐	☐	Psychotherapy			

Please circle the area of current complaint.



Signature: _____Date:_____

Please note: Your appointment time is your treatment time. **Please cancel appointments no less than 24 hours prior or a full fee will be charged.** The same applies for missed appointments.

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INFORMED CONSENT: MASSAGE THERAPY

I hereby request and consent to the performance of soft tissue manipulation and other massage therapy techniques including:

- Hydrotherapy
- Trigger point release
- Joint mobilizations

I have had the opportunity to discuss these techniques and their purpose in my treatment with the Massage Therapist named below.

I understand that I may refuse treatment at any time and I have been informed of risks, if any involved in my soft tissue therapy treatment. I have been made aware of how this treatment will be performed for my condition.

I have informed the Massage Therapist named below all current medical information. I will inform the therapist of any changes in my health status.

I have read the above consent. I have also had the opportunity to ask questions about its consent and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Privacy Policy: Please review the attached **Privacy Policy Overview.** This policy has been written with the guidelines set out by the Privacy Commissioner of Canada. (Personal Information Protection and Electronic Documents Act).

_____ _____
Client name (print) Signature of Client or Legal Guardian

_____ _____
Therapist Signature Date