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NOTTINGHILL FAMILY WELLNESS CENTRE
MASSAGE REGISTRATION FORM

PATIENT INFORMATION

Patient's name:			**DOB (MMDDYY):**
Street Address:			**City:**
Province:	**Postal Code:**	**Cell phone no.:** ( )	**Occupation:**
E-Mail:		**How did you hear about us:**	

MEDICAL CONDITIONS

Please review this list and circle any illnesses and/or conditions that apply:

☐ Loss of Balance	☐ Scoliosis	☐ Painful joints	☐ High blood pressure
☐ Diabetes	☐ Other	☐ Previous MVA/trauma	☐ Low blood pressure
☐ Arthritis	☐ Pins/needles/ numbness/tingling	☐ Fatigue/depression	☐ Auto-immune disorder
☐ Seizures	☐ Ruptured/bulging discs	☐ Asthma	☐ Skin disorder
☐ Cancer	☐ Headaches	☐ Shortness of breath	☐ Vision problems/loss
☐ Stroke	☐ Varicose veins/phlebitis	☐ Heart conditions	☐ Hearing problems/loss

Allergies :

Family History:	**Do you have any of the following:**	**For Women:**
☐ Cardiovascular	☐ Pacemaker or similar devices	☐ Pregnant, due:
☐ Respiratory	☐ Internal pins or wires	☐ Gynecological conditions:
☐ Cancer	☐ Artificial joints/special equipment	_____
	☐ Other:	

Overall, how is your general health?

What are the reasons that you have chosen massage therapy?

Medications:
- ☐ Muscle relaxants
- ☐ Over-the-counter pain reducers
- ☐ Prescription pain reducers
- ☐ Sleeping pills
- ☐ Anti-inflammatory
- ☐ Anti-anxiety/depressants
- ☐ Other:

Please indicate any surgeries or injuries that have occurred:

Date ( ) _____

Date ( ) _____

Date ( ) _____

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Cell phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Nottinghill Family Wellness Centre. I understand that I am financially responsible for any balance owing. I also authorize Nottinghill Family Wellness Centre and my insurance company to release any information required to process my claims. The nature and purpose of the assessment will be discussed and I will be given the opportunity to ask questions. Prior to treatment, I will be informed of the areas which will be treated, the proper positioning and draping on the table. I understand I have the ability to refuse, alter or rescind consent at any time throughout the treatment. I understand that my personal information is confidential and will not be released to a third party without my written permission or required by law.

CANCELLATION POLICY: Please notify us at least 24 hours prior to scheduled appointments. The cancellation fee will be equal to the cost of the missed appointments, if not given 24 hours advanced notice.

_____ _____

Patient/Guardian Signature ***Date***