# 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

_____

_____

**Fee and Cancellation Policy**

All payments will be due upon services rendered. Massage is not a benefit of OHIP. However, many private Health Insurance Policies include Massage Therapy coverage (e.g. PSHP, formerly GSMIP). Twelve hours notice is required for cancellation of your appointment otherwise you will be billed a treatment fee of $50.00.

**Consent Policy**

Your comfort and trust in this clinic is very important. You are encouraged to actively participate by communicating before during and after therapy about any aspects of the treatment. The massage therapist respects your right to give informed and voluntary consent regarding care and treatment before providing treatment and that you have the right to make changes regardless of prior consent given.

Signature: _____ Date: _____