Country Hills Chiropractic & Wellness

MASSAGE THERAPY

Full Name Dr Mr Mrs Ms Miss_____ Birth Date _____ /____/ _____
dd / mm / yy

Address_____

City _____ Province _____ Postal Code _____

Phone (res) (____) _____ Phone (wk) (____) _____Phone (cell) (____) _____

Email _____

Employer _____ Occupation _____

Age _____ Height _____ Weight _____

If under 18 name of responsible party_____

Your major complaint or symptom is _____

Medications: _____ Reason for taking: _____

Name of family Physician_____

Who referred you or how did you hear about our clinic? (circle one and please specify name)

Family Member Friend Physician Phone Book _____
name

Please answer the following questions by circling the appropriate answer. If Yes please explain

1. Have you had a professional massage before? NO YES_____
2. Have you ever had surgery? NO YES_____
3. Do you have any spinal problems? NO YES_____
4. Are you pregnant? NO YES_____
5. Do you wear contact lenses or dentures? NO YES_____
6. Do you take an prescribed medications? NO YES_____
7. Do you have chronic back pain? NO YES_____
8. Do you have frequent headaches? NO YES_____

9. **Are you constantly tired? NO YES**_____

10. **Do you have any heart problems? NO YES**_____

11. **Do you have high blood pressure? NO YES**_____

12. **Do you have varicose veins? NO YES**_____

13. **Do you have any blood clots? NO YES**_____

14. **Have you ever had cancer? NO YES**_____

15. **Do you have arthritis? NO YES**_____

16. **Have you suffered any acute injury/accident? NO YES**_____

17. **Do you have pain which radiates down legs or arms? NO YES**_____

18. **Do you suffer from tension? NO YES**_____

19. **Do you have chronic diarrhea? NO YES**_____

20. **Do you have chronic constipation? NO YES**_____

21. **Do you smoke? If yes, how much per day? NO YES**_____

22. **Do you have diabetes? NO YES**_____

23. **Do you see a Chiropractor? If yes, name of doctor:** _____

I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist prescribes neither medical treatment nor pharmaceuticals, nor performs any spinal manipulations. It has been made very clear to me that this massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

I am also aware that the clinic requires a 24 hour cancellation notice for all massage appointments and that a fee of the full charge of the massage will be charged if less then 24 hours notice is given.

Signature of patient_____ **Date:** _____
(or parent/guardian)