St. Margaret's Bay MASSAGETHERAPY

Name: _____ Date: _____

Complete Mailing Address:_____

_____

Postal Code

Home Phone: _____ Work: _____ Cell: _____

Email Address: _____

Date of Birth: _____ (**mm-dd-yyyy**) Occupation:_____

Family Medical Doctor: _____ Phone: _____

Emergency contact info:_____ How did you hear about our clinic? _____

Please advise the receptionist if you have private health insurance, we may be able to arrange direct billing for you. PLEASE NOTE: If your healthcare plan requires a Doctor referral, it must be renewed annually. If your referral is not current and/or the claim is disputed by your Healthcare Provider, payment in full will be required on the date of service. It is the responsibility of the client to investigate any disputed claims with the healthcare provider.

Are you here due to a motor vehicle accident? (**YES / NO**) If **YES**, Date of accident: _____

Your major area of pain: _____ When did this condition begin?_____

Have you had this or a similar complaint previously**? (YES / NO)**

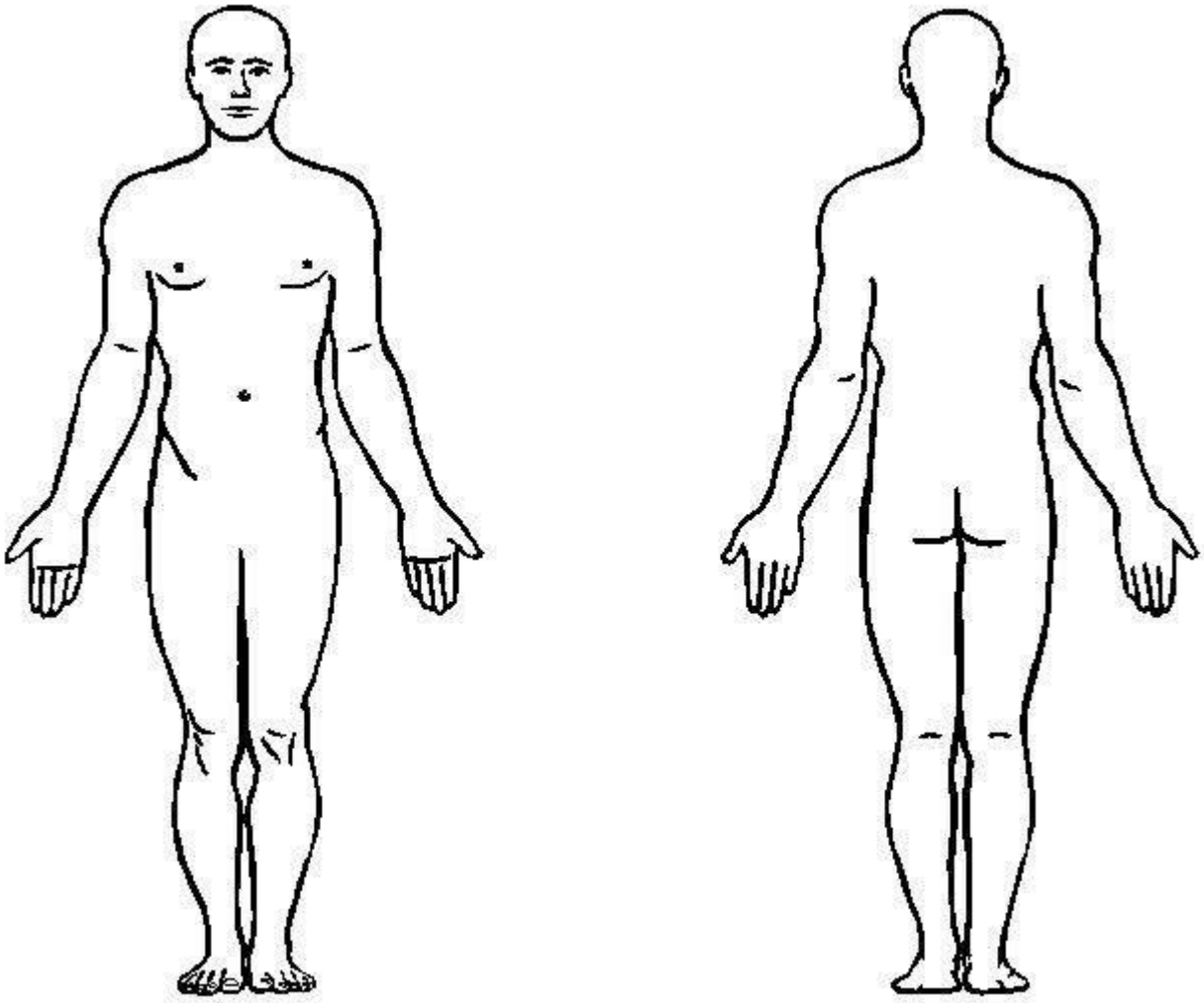
If pregnant, please indicate your due date: _____

Medical Conditions	***(Check if YES)***	***Please provide details***
Allergies		
Arthritis/Osteoarthritis		
Cancer		
Cardiac/Lung Conditions		
Diabetes		
Epilepsy		
Heart Attack/Stroke		
Hemophilia		
High Blood Pressure		
Infectious Diseases		
Low Blood Pressure		
Pins, plates, prosthesis?		
Skin Conditions		
Past Surgery		
Please list Medications –		

PLEASE COMPLETE BACK OF FORM→→→

On the diagram below please circle the area(s) of your chief complaint(s)

R **L** **L** **R**



FRONT **BACK**

Appointment cancellations not received within 24 hours prior to scheduled treatment time will result in payment of the full treatment fee.

I, _____ fully understand the purpose, procedure and benefits of this
(Please Print)

Massage Therapy treatment and therefore give my consent (If under the age 18, please have parent or guardian sign)

_____
(Signature)