

**NOTTINGHILL FAMILY WELLNESS CENTRE
MESSAGE REGISTRATION FORM**

Suite 205, 1131 Nottinghill Gate
Oakville, On, L6M 1K5
glenabbeychiro.com
E: s.knighton.dc@gmail.com
T: 905-827-4197 F : 905-827-6945

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

Allergies :		
Family History: <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Respiratory <input type="checkbox"/> Cancer	Do you have any of the following: <input type="checkbox"/> Pacemaker or similar devices <input type="checkbox"/> Internal pins or wires <input type="checkbox"/> Artificial joints/special equipment <input type="checkbox"/> Other:	For Women: <input type="checkbox"/> Pregnant, due: <input type="checkbox"/> Gynecological conditions: _____

Overall, how is your general health? What are the reasons that you have chosen massage therapy?	Medications: <input type="checkbox"/> Muscle relaxants <input type="checkbox"/> Over-the-counter pain reducers <input type="checkbox"/> Prescription pain reducers <input type="checkbox"/> Sleeping pills <input type="checkbox"/> Anti-inflammatory <input type="checkbox"/> Anti-anxiety/depressants <input type="checkbox"/> Other:
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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.:
<p>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.</p> <p>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.</p>		
_____	_____	_____
Patient/Guardian Signature		Date