# NOTTINGHILL FAMILY WELLNESS CENTRE
# REGISTRATION FORM

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Today's date: | | DOB: / / | AGE: |
| Patient's last name: | | First: | |
| Street address: | | | Home phone no.: ( ) |
| City: | Province: | Postal Code: | Cell phone no.: ( ) |
| Occupation: | Employer: | | |

How did you hear about us: ❑ Dr. _____

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Website ❑ Other

## INSURANCE INFORMATION

| | | | |
|---|---|---|---|
| Insurance Member: | Birth date: / / | Group no.: | Policy no.: |

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

## MEDICAL CONDITIONS

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

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

**Allergies** : _____

_____

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

**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 ( ) _____

Date ( ) _____

Date ( ) _____

## IN CASE OF EMERGENCY

| Name of local friend or relative: | Relationship to patient: | Home phone no.: ( ) | Work 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*

Date of initial Health History: _____

Update 1 _____

Update 2 _____

Update 3 _____

Update 4 _____