Oxford Wellness Clinic

15152 127 Street NW Edmonton, AB T6V0C5
Phone: 780.758.8323 Fax: 780.669.5829
www.oxfordwellnessclinic.ca

MASSAGE PATIENT REGISTRATION

Please print clearly

Name: ______________________/______________________/________ Gender: M / F

Last First M.I.

Address: __________________________/__________/_______/____________

Street City Prov Postal Code

Date of Birth (DD/MM/YYYY): ____________________/ Age: _______/ Height: ______/ Weight: ______

Phone (Cell) (____) ______________________

Phone (Home) (____) ______________________

Phone (Work) (____) ______________________

Email: ______________________________

Occupation: ______________________________

Referred by: ______________________________

Relationship to you: ______________________________

Alberta Health Care #: ______________________

Insurance Company: ______________________

Claim / ID #: ______________________

Plan / Group #: ______________________

Cardholder Name: ______________________

EMERGENCY CONTACT INFORMATION

Name: ______________________________

Phone Number: ______________________________

Relationship: ______________________________

Family Doctor Contact Info: ______________________________

Appointment Reminders

*To receive text/email reminders please circle either: EMAIL or TEXT and Cell phone service provider: ____________

60 Minute Massage Visit	$110.00 (Including GST)
90 Minute Massage Visit	$145.00 (Including GST)

Please be aware you are responsible for the balance of the above fee schedule at the time of service.

Oxford Wellness Clinic asks that you please provide 24 hours' notice of cancellation. However, we understand that unexpected events may arise. As a courtesy, please notify the clinic as soon as possible. The front office will be happy to reschedule your appointment.

Our employees depend on you to respect their availability, please make every effort to arrive for your scheduled appointment. In order to ensure we can accommodate all of our patients' scheduling needs, we do require 24 hour notice for cancelations.

Repeat NO Show appointments may result in a $ 50.00 No show fee

The no-show fee cannot be direct billed to any insurance company for services not rendered, payment must be made prior to any future treatments.

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Have you had previous massage care? ☐ Yes ☐ No

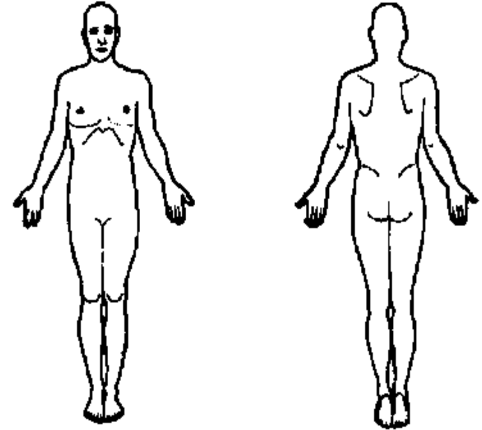
Is this a work-related injury? ☐ Yes ☐ No

Has your employer been notified? ☐ Yes ☐ No

Is this a Motor Vehicle Accident (MVA)? ☐ Yes ☐ No

Date of Accident: ____

Please indicate the areas of complaint:



| 0 1 2 3 4 5 6 7 8 9 10 |

No pain Extreme pain

What kinds of exercise do you do?______________________________
____
____

List all previous injuries, surgeries, illnesses, (including MVA):
____
____

List all medications, over the counter and prescriptions, supplements, vitamins, herbal supports, aspirin, etc.:
____
____

Massage Therapy Consent

I, ____, understand that the massage therapist is not a physician and cannot diagnose any physical or mental illnesses. I understand that it is recommended that I continue to see my physician for any ailment I might be experiencing. I acknowledge that no guarantee has been made to me as to the results of the treatment. I have completed my health history form as provided by my massage therapist and I have disclosed all medical conditions that are affecting me. The information I have provided is true and complete to the best of my knowledge.

I understand that the treatment may cause some discomfort at times, and I acknowledge that I, and the therapist, can discontinue the treatment(s) at any time.

Signature: ____ Date: ___________________________________

RMT Signature: ____ Date: __________________________________

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GENERAL SYMPTOMS	RESPIRATORY	GENITOURINARY
Fever Sweats Fainting Sleep disturbance Fatigue Nervousness Weight loss Weight gain	Chronic cough Spitting up phlegm Spitting up blood Chest pain Wheezing Difficulty breathing Asthma	Frequent urination Painful urination Blood in urine Pus in urine Kidney infection Prostate trouble Uncontrollable urine flow
NEUROLOGICAL	**CARDIOVASCULAR**	**GASTROINTESTINAL**
Visual disturbance Dizziness Fainting Convulsions Headache Numbness Neuralgia (nerve pain) Poor coordination Weakness	Rapid beating heart Slow beating heart High blood pressure Low blood pressure Pain over heart Hardening of arteries Swollen ankles Poor circulation Palpitations Cold hands or feet Varicose veins	Poor appetite Difficult digestion Heartburn Ulcers Nausea Vomiting Constipation Diarrhea Blood in stool Gallbladder/Jaundice Colitis
EYES, EARS, NOSE, THROAT	**MUSCLE & JOINT**	**FOR WOMEN ONLY**
Eye pain Double vision Ringing in ears Deafness Nosebleeds Trouble swallowing Hoarseness Sinus infection Nasal drainage Enlarged glands	Neck pain Low back pain Arm pain Shoulder pain Leg pain Knee pain Foot pain Pain/numbness down arms or legs Pain between shoulders Swollen joints Spinal curvature Arthritis Fractures	Painful menstruation Hot flashes Irregular cycle Cramps or back pain Vaginal discharge Nipple discharge Lumps in breast Menopausal symptoms Birth control pills Miscarriages Complications with pregnancy Pregnant? Y / N Week? Other:

Systems Review Circle any conditions that are presently causing you a problem.
Underline those that have caused you problems in the past.