MASSAGE THERAPY

Confidential Patient History Form

Name: _____ Date: _____

Birth Date: YYYY / MM / DD File Number: _____

Address: _____

Contact Information

E-mail: _____ Home phone: _____

Cell phone: _____ Work phone: _____

Please select your preference for appointment reminders:

☐ E-mail ☐ Text ☐ Home phone ☐ Work phone

Care Card # _____

ICBC ☐ Claim # _____ Date of Accident: _____

Adjusters Name: _____ Have you informed ICBC you are claiming injuries? _____

Occupation _____

How did you hear about (Registered) Massage Therapy? _____

Please indicate if you believe any of the following apply to you? (**P** = Past **C** = Current) Circle if necessary.

- ☐ Heart attack
- ☐ High/low blood pressure
- ☐ Stroke or aneurysm
- ☐ Pace maker
- ☐ Other heart condition
- ☐ Varicose veins
- ☐ Bruise easily
- ☐ Other circulatory condition

- ☐ Diabetes
- ☐ Kidney disease
- ☐ Other Urinary condition

- ☐ Headaches/migraines
- ☐ Dizziness/fainting
- ☐ Nausea
- ☐ Spinal injury
- ☐ Head injury
- ☐ Epilepsy/other seizures
- ☐ Other neurological condition

- ☐ Asthma
- ☐ Chronic sinusitis
- ☐ Other respiratory condition

- ☐ Irritable bowel/colitis
- ☐ Digestive condition
- ☐ Skin condition

- ☐ Joint dislocation
- ☐ Bone fracture
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Rods/pins/plates/shunts
- ☐ Implants _____
- ☐ Transplant_____
- ☐ Corrective lenses/contacts

- ☐ Cancer _____
- ☐ Hepatitis
- ☐ HIV
- ☐ Other Contagious condition _____

Please list any medications you presently take:

_____

_____

Known allergies (including medications, foods, seasonal, oils and lotions, etc.)

_____

Do you have any family history of medical conditions? ☐ Yes ☐ No

Please list: _____

_____

Have you ever been hospitalized, had any major accidents, illnesses, or surgeries? ☐ Yes ☐ No

Please comment: _____

_____

Name: _____ Patient History Form cont...
File Number: _____
Date: _____

Other therapy/treatment: (past or present, does not have to be related to this visit)

	Date of last visit:	Location:
☐ Massage therapy	_____	_____
☐ Chiropractic	_____	_____
☐ Physiotherapy	_____	_____
☐ Naturopathy	_____	_____
☐ Acupuncture	_____	_____
☐ Other _____	_____	_____

List any activities, sports, hobbies:
(ie. jogging, hockey, crafts, computer; etc.)

_____
_____
_____

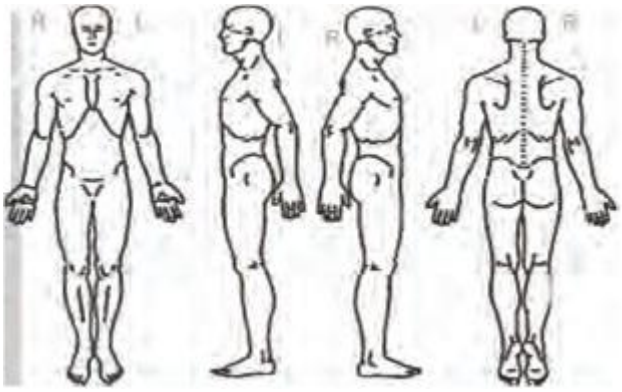
List any NON-prescription vitamins, minerals or other supplements you are taking:

_____
_____
_____

Please CIRCLE the answer closest to how you PRESENTLY feel: (1 = poor, 5 = excellent)

Quality of Sleep	1	2	3	4	5	Smoker?	Yes	No	Occasionally
Energy Level	1	2	3	4	5	Alcohol?	Yes	No	Occasionally
Eating Habits	1	2	3	4	5				
Stress Level	1	2	3	4	5				
Exercise Habits	1	2	3	4	5				

Current Condition
Please indicate on the diagram the nature of your symptoms, using the symbols indicated:



Aching	OOO
Stabbing	XXX
Shooting	→ →
Burning	###
Numbness/Tingling	≈ ≈

Please Note: We ask that you provide us with ***24 hours notice of cancellation***, or a cancellation fee of $50.00 will be charged. Payment for all treatment is required the time of appointment.

I authorize the clinic and its associated RMT to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated RMT to communicate with my referring MD as deemed necessary for my beneficial treatment. I understand all risks and benefits associated with the treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with permission.

Signature: _____ Date: _____