

Confidential Patient History Form

Label Placement

Date _____

Contact Information

E-mail: _____ Home phone: _____ Work phone: _____

Cell phone: _____ Cell phone Carrier (i.e. Rogers, Telus, etc.): _____

Please select your preference for appointment reminders:

E-mail Text Home phone Work phone

Appointments can be booked on-line: info@abbotsfordspinecentre.ca

Care Card # _____

ICBC Claim # _____

WCB Claim # _____

(If active claim, please inform RMT as you will need to fill out the related Claim Form)

Occupation _____

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

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

<input type="checkbox"/> Heart attack	<input type="checkbox"/> Headaches/migraines	<input type="checkbox"/> Joint dislocation
<input type="checkbox"/> High/low blood pressure	<input type="checkbox"/> Dizziness/fainting	<input type="checkbox"/> Bone fracture
<input type="checkbox"/> Stroke or aneurysm	<input type="checkbox"/> Nausea	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Pace maker	<input type="checkbox"/> Spinal injury	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Other heart condition	<input type="checkbox"/> Head injury	<input type="checkbox"/> Rods/pins/plates/shunts
<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Epilepsy/other seizures	<input type="checkbox"/> Implants _____
<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Other neurological condition	<input type="checkbox"/> Transplant _____
<input type="checkbox"/> Other circulatory condition		<input type="checkbox"/> Corrective lenses/contacts
 	<input type="checkbox"/> Asthma	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Chronic sinusitis	<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Other respiratory condition	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Other Urinary condition		<input type="checkbox"/> HIV
	<input type="checkbox"/> Irritable bowel/colitis	<input type="checkbox"/> Other Contagious condition
	<input type="checkbox"/> Digestive condition	_____
	<input type="checkbox"/> Skin 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: _____

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

- Massage therapy
- Chiropractic
- Physiotherapy
- Naturopathy
- Acupuncture
- Other _____

Date of last visit

Location

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

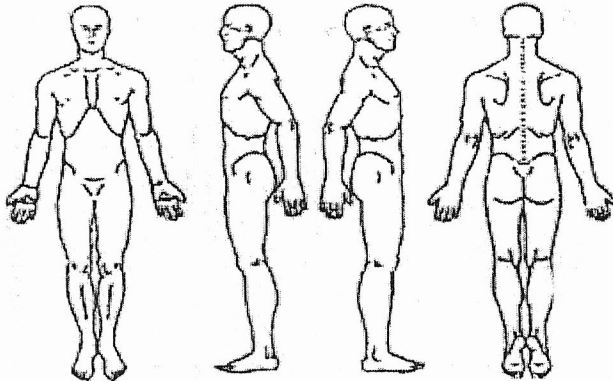
List any NON-prescription vitamins, minerals
or other supplements you are taking:

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 ≈ ≈
- or Tingling

Please Note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancelation fee of \$50.00 for 1 hour, \$37.50 for 45min, and \$25 for 30min will be charged. Payment for all treatment, whether private or insure, is ultimately the responsibility of the patient. All NDI & OSW results will be transferred if applicable.

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 associates 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: _____