

CONFIDENTIAL PATIENT HISTORY FORM



SAFE, EFFECTIVE HEALTH CARE

Name _____

Birthdate _____

(month / day / year)

Address _____

Family Doctor _____

Phone _____

Postal Code _____

Referring Professional _____

Phone (home) _____

Phone _____

(cell/pager) _____

(work) _____

Email _____

Occupation _____

Care Card # _____

Extended Medical Insurer _____

ICBC or WCB? No Yes Claim# _____

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

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

How did you hear about our clinic? _____

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"/> Depression | <input type="checkbox"/> Corrective Lenses/Contacts |
| <input type="checkbox"/> Anxiety | <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)

<input type="checkbox"/> Massage Therapy	Date of last visit _____	Location _____
<input type="checkbox"/> Chiropractor	“ _____	“ _____
<input type="checkbox"/> Physiotherapy	“ _____	“ _____
<input type="checkbox"/> Naturopath	“ _____	“ _____
<input type="checkbox"/> Acupuncture	“ _____	“ _____
<input type="checkbox"/> 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	Hours of sleep per night (approx.)	_____
Energy Level	1	2	3	4	5	Number of meals you regularly eat per day	_____
Eating Habits	1	2	3	4	5	Number of times you exercise per week	_____
Stress Level	1	2	3	4	5		
Exercise Habits	1	2	3	4	5		

Smoker	Yes	No	Occasional
Alcohol	Yes	No	Occasional

Current Condition

Please describe your current condition & symptoms: _____

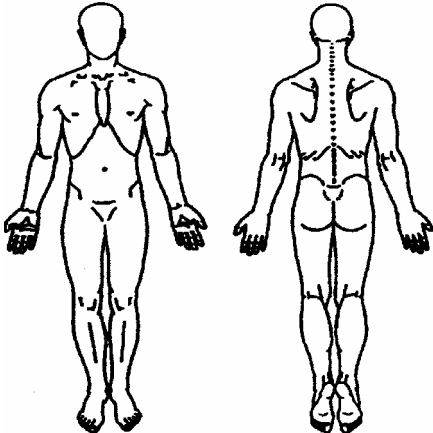
How long have you had this condition? _____

How did it start? _____

What aggravates it? _____

What relieves it? _____

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



Aching	○ ○
Stabbing	X X X
Shooting	→ →
Burning	# # #
Numbness or Tingling	≈ ≈

Sharing of My Patient Record: My initials confirm that I request and authorize my RMT to provide to the Clinic and to other health care practitioners who provide me with treatment, copies of any patient record created by my RMT. I understand this will enable the Clinic to maintain a complete patient record on my behalf. I understand that I may revoke this permission in writing at any time in the future.

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 cancellation fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

I authorize the clinic and its associated RMTs 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 RMTs to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature: _____ **Date:** _____