CONFIDENTIAL PATIENT HISTORY FORM

Name					**Birthdate**		
Address							
Phone	**Home**		**Cell**		**Work**		
Email			**Occupation**				
Family Doctor			**Referring Professional**				

How did you hear about (Registered) Massage Therapy?						
How did you hear about our clinic?						
ICBC Related?	**Yes**		**No**		**Claim#**		**Accident Date:**

If Active Claim, please inform RMT as you will need to fill out the related Claim Form

Is the reason for your visit to our clinic, due to a work related injury?	**Yes**		**No**	
Do you have a WCB Claim?	**Yes**		**No**	
Have you ever had a WCB claim?	**Yes**		**No**	
Have you ever had a claim denied?	**Yes**		**No**	

Other Therapy/Treatment (Past or Present, DOES NOT have to be related to this visit)			
Treatment Type	**Date of Last Visit (Approx.)**	**Treatment Type**	**Date of Last Visit (Approx.)**
Massage Therapy		**Physiotherapy**	
Chiropractor		**Naturopath**	
Rolfing		**Acupuncture**	
OTHER			

List any Activities, Sports, Hobbies (ie. Jogging, Hockey, Crafts, Computer, etc)

Please indicate if any of the following conditions apply to you: (P = Past / C = Current) Circle if necessary.					
Heart Attack		Headaches / Migraines		Skin Condition	
High / Low Blood Pressure		Dizziness / Fainting		Joint Dislocation	
Stroke or Aneurysm		Nausea		Bone Fracture	
Pace Maker		Spinal Injury		Arthritis	
Other Heart Condition		Head Injury		Osteoporosis	
Varicose Veins		Epilepsy / Other Seizures		Rods / Pins / Plates / Shunts	
Bruise Easily		Other Neurological Condition		Implants	
Other Circulatory Condition		Asthma		Transplant	
Diabetes		Chronic Sinusitis		Corrective Lenses / Contacts	
Kidney Disease		Other Respiratory Condition		Cancer	
Other Urinary Condition		Irritable Bowel / Colitis		Hepatitis	
High Cholesterol		Digestive Condition		HIV	
Vertigo		Other Contagious Condition			

Please list any Doctor Prescribed medications you presently take. (Please let us know if you require more space)

Please list any Non-prescription vitamins, minerals, supplements or pain relievers

Known Allergies :	

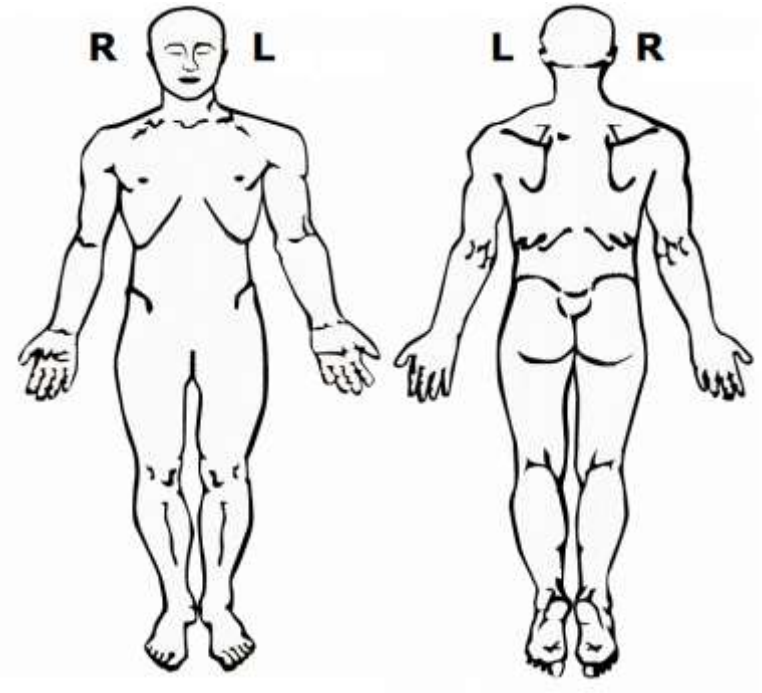
Family History of Medical Conditions?	

Have you ever been hospitalized, major accidents, illnesses, or surgeries?	Please Circle One: YES / NO

If YES, Please List Below:		
INJURY / SURGERY / ILLNESS / ACCIDENT	WHEN?	THERAPY RECEIVED?

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	Occasional
Energy Level	1	2	3	4	5	Alcohol	Yes	No	Occasional
Eating Habits	1	2	3	4	5	Hours of sleep per night (Approx.)			
Stress Level	1	2	3	4	5	Meals regularly eaten per day			
Exercise Habits	1	2	3	4	5	Times you exercise per week			

Current Condition - Please describe your current condition & symptoms:	
How long did you have 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	**O O**
Stabbing	**X X X**
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 cancellation fee (full session fee) will be charged**. Payment for all treatment is the responsibility of the patient and will be paid in advance of the treatment/consult session.

I authorize the clinic, and its associated practitioners 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's 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.

Patient/Guardian Signature: **Date:**