

**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.

- |                                                      |                                                       |                                                     |
|------------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------|
| <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 |
| <br>                                                 | <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: \_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

File Number: \_\_\_\_\_

Date: \_\_\_\_\_

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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

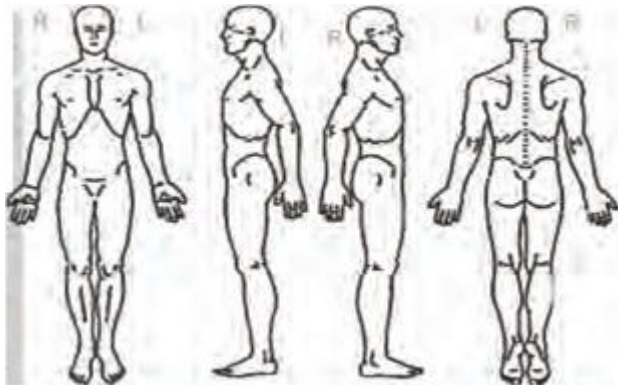
\_\_\_\_\_

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/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: \_\_\_\_\_