File Number: _____

REGISTERED MASSAGE THERAPY

Confidential Patient History Form

Name: _____ Date: _____

Birth Date: YYYY / MM / DD Gender: _____

Address: _____

Postal Code: _____ Email: _____

Home Phone: _____ Cell: _____

Care Card # _____

Please select your preference for appointment reminders: ☐ **Email / ☐ Text / ☐ Phone**

☐ Phone call 24 hrs before appointment ☐ Text or Email 1 hr before appointment

☐ Text or Email 24 hrs before appointment ☐ Text or Email 2 days before appointment

ICBC ☐ Claim # _____ Date of Accident: _____

Adjusters Name: _____

Have you informed ICBC you are claiming injuries? ☐ Yes ☐ No

Occupation _____

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

What brings you in today? ☐ Fall ☐ Accident ☐ Other _____

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

- □ 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.):

_____

Patient History Form Continued...

File Number: _____

Name: _____

Date: _____

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)

	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:

_____

_____

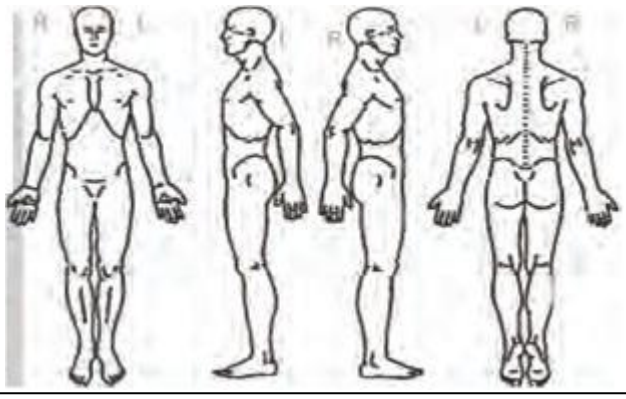
_____

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	≈ ≈