CONFIDENTIAL PATIENT HISTORY FORM

SAFE, EFFECTIVE HEALTH CARE

Andrea Hird, RMT
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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.

- ☐ Heart Attack
- ☐ High / Low Blood Pressure
- ☐ Stroke or Aneurysm
- ☐ Pace Maker
- ☐ Other Heart condition
- ☐ Varicose Veins
- ☐ Bruise easily
- ☐ Other Circulatory condition
- ☐ Anxiety
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Other Urinary condition
- ☐ Headaches / Migraines
- ☐ Dizziness / Fainting
- ☐ Nausea
- ☐ Spinal Injury
- ☐ Head Injury
- ☐ Epilepsy / other seizures
- ☐ Other Neurological condition
- ☐ Depression
- ☐ Asthma
- ☐ Chronic Sinusitis
- ☐ Other Respiratory condition
- ☐ Irritable Bowel / Colitis
- ☐ Digestive condition
- ☐ Skin 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.)

_____

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: _____

_____

Continued ver.o.

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

	Date of last visit	Location
☐ Massage Therapy		
☐ Chiropractor	"	"
☐ Physiotherapy	"	"
☐ Naturopath	"	"
☐ 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
Energy Level	1	2	3	4	5
Eating Habits	1	2	3	4	5
Stress Level	1	2	3	4	5
Exercise Habits	1	2	3	4	5

Hours of sleep per night (approx.) ___

Number of meals you regularly eat per day ___

Number of times you exercise per week ___

Smoker	Yes	No	Occasional
Alcohol	Yes	No	Occasional

Current Condition

Please describe your current condition & symptoms: _____

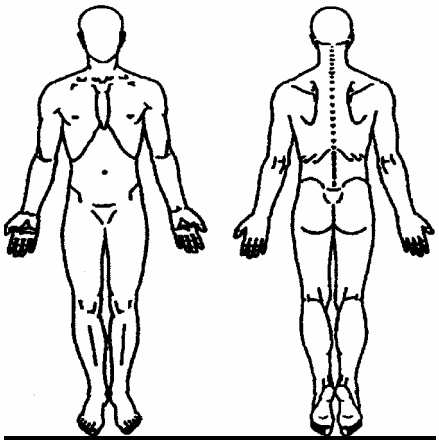
How long have you had this condition? _____

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	O O
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:**