

CONFIDENTIAL PATIENT HISTORY FORM



SAFE, SMART, EFFECTIVE HEALTH CARE

BODY: HEALTHY
REGISTERED MASSAGE THERAPY



Name _____ **Birthdate** _____
(month / day / year)

Address _____ **Family Doctor** _____
Phone _____

Postal Code _____ **Referring Professional** _____
Phone _____

Phone (home) _____
(cell/pager) _____
(work) _____

Care Card # (If BCMSP eligible) _____
ICBC Claim: Date of Injury: _____

Email (optional) _____

Occupation _____

Please note that Wendy McLean, RMT is an opted-out practitioner, meaning that the patient is billed directly and is responsible for recovering reimbursement from their insurer(s).

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"/> Corrective Lenses/Contacts |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> other Urinary condition | <input type="checkbox"/> other Respiratory 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"/> other Conditions |
| | <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: _____

Please list any 'minor' injuries that might be helpful to aid assessing your condition - including sports injuries, falls, head or tailbone injury, loss of consciousness: _____

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	≈ ≈

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: _____