CONFIDENTIAL PATIENT HISTORY FORM

SAFE, SMART, EFFECTIVE HEALTH CARE

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

_ 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
_ 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 over...