CONFIDENTIAL PATIENT HISTORY FORM

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

Address ________________________ **Family Doctor** ________________________

________________________ Phone ____________

Postal Code ____________ **Referring Professional** ________________________

Phone (home) ____________ Phone ____________

(work) ____________

(cell/pager) ____________ **ICBC or WCB?** ❑ No ❑ Yes (if yes, please ask for extra forms)

Email ________________________

Occupation ________________________

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 Conditions

__ 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 ____________

Are you pregnant? ❑ Yes ❑ No

Please Comment: ________________________

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…

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

❑ Massage Therapy	Date of last visit	____________	Location	________________
❑ 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?

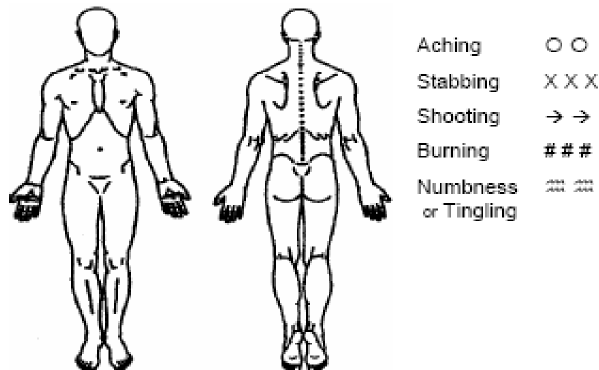
____

How did it start? ___________________________
____

What aggravates it? ___________________________
____

What relieves it? ___________________________
____

Please indicate on the diagram the nature of your symptoms, using the symbols indicated:



Patient Consent

The Registered Massage Therapists at Sumas Mountain Chiropractic & Wellness Clinic make every effort to ensure your treatment is safe and effective. The approach to treatment may vary depending on your condition(s). At any time before or during the massage treatment, you have the right to ask that the treatment, or portion of, be discontinued. If you have any questions or concerns related to the treatment or techniques used, we encourage you to communicate this to your therapist.
This case history form will be kept as a part of your patient file. All information within your file will be kept confidential and will not be released without your prior consent. You will be required to pay for any treatment related fees which have not been or are not covered by your health insurance or ICBC.
Please sign below to indicate that you have read and understood the above and that the information you provided in this case history form is accurate.
PLEASE NOTE: If you are unable to keep an appointment with the massage therapist, and have failed to give 24 hour notice, a cancellation fee will be charged.

I hereby acknowledge that all of the information herein is correct to the best of my ability:

Signature of Patient:_______________________________________ Date:___________________________
-or parent/guardian if under 19 years