# CONFIDENTIAL PATIENT HISTORY FORM

SAFE, SMART, EFFECTIVE HEALTH CARE

**Name** _____

**Address** _____

_____

**Postal Code** _____

**Phone** (home) _____

(cell) _____

(work) _____

_____

**Occupation** _____

**Would you like to hear more about Harmony events &promotions?**
**Yes___ No___**

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

**Emergency contact**_____

**Family Doctor** _____

Phone _____

**Referring Professional**_____

Phone _____

**ICBC or WCB?** No___Yes___Claim #_____
(if active claim, please inform your RMT as you will need to fill out the related Claim Form)

**Email**_____

**Would you prefer Email or Phone Call Reminders?**
Email ___ Phone___

**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: _____

_____

**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: _____

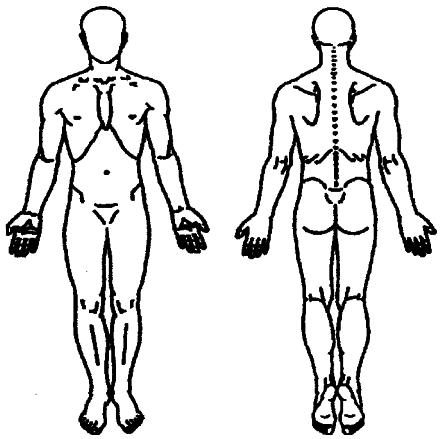
How long have you had this condition? _____

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 | Z Z |

**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:**