Confidential Patient Care History Form

Name _____ Daytime Phone _____

Birth date _____ Evening Phone _____

Address _____

City _____ Occupation _____

Postal Code _____ Family Dr. _____

Email _____ May we send you occasional emails? ☐ **No** ☐ **Yes**

How did you hear about our services?

_____

_____

Are you currently involved in a WCB claim or an ICBC litigation/claim? ☐ **No** ☐ **Yes**

Please indicate conditions you are experiencing or have experienced:

Condition	**Present**	**Past**	**Condition**	**Present**	**Past**
Headaches	☐	☐	Chronic cough	☐	☐
Migraines	☐	☐	Shortness of Breath	☐	☐
Dizziness	☐	☐	Bronchitis	☐	☐
Fainting	☐	☐	Asthma	☐	☐
Anxiety	☐	☐	Emphysema	☐	☐
Eye/Visual Problems	☐	☐	Gastrointestinal problems	☐	☐
Osteoarthritis	☐	☐	Constipation	☐	☐
Rheumatoid Arthritis	☐	☐	Irritable Bowel Syndrome	☐	☐
Muscle spasms	☐	☐	Kidney disease	☐	☐
Muscle tension	☐	☐	Liver disease	☐	☐
Muscle strain	☐	☐	Diabetes	☐	☐
High blood pressure	☐	☐	Skin conditions	☐	☐
Low blood pressure	☐	☐	HIV / AIDS	☐	☐
Heart disease	☐	☐	Hepatitis	☐	☐
Heart attack	☐	☐	Cancer	☐	☐
Varicose veins	☐	☐	Epilepsy	☐	☐
Stroke/CVA	☐	☐	Allergies	☐	☐
Bruise easily	☐	☐	Osteoporosis	☐	☐
Chronic congestive heart failure	☐	☐	Menstrual difficulties	☐	☐

Do you have any medical conditions not listed above?

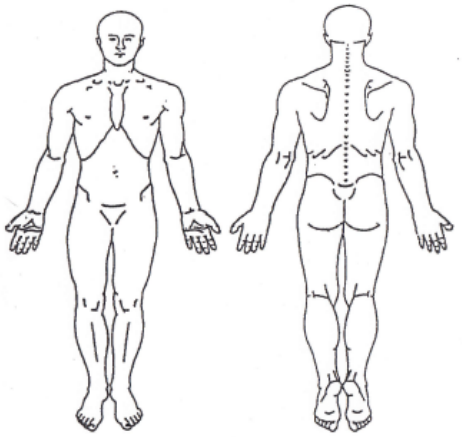
_____

_____

_____

PLEASE TURN PAGE OVER

Please note, using the check boxes below and shading in the diagram which areas are currently causing you symptoms of pain, stiffness, numbness or other forms of discomfort:



☐ Face	☐ Ribs	☐ Hip(s)
☐ Neck	☐ Arm(s)	☐ Thigh(s)
☐ Shoulders	☐ Elbow(s)	☐ Buttock(s)
☐ Chest	☐ Wrist(s)	☐ Leg(s)
☐ Upper Back	☐ Tailbone	☐ Ankle(s)
☐ Middle Back	☐ Hand(s)	☐ Feet
☐ Lower Back	☐ Finger(s)	☐ Toes(s)

For what reason are you seeking treatment today?

_____

Have you seen any other health care professional(s) for this condition or reason? ☐ **No** ☐ **Yes**

If so, whom? _____

Have you ever been involved in any auto accidents? ☐ **No** ☐ **Yes** **Date:** _____

Have you ever been involved in any other accidents? ☐ **No** ☐ **Yes** **Date:** _____

Have you ever been knocked unconscious? ☐ **No** ☐ **Yes** **Date:** _____

Briefly list any surgeries you have undergone, for what, and when:

_____

_____

_____

Are you a smoker? ☐ **No** ☐ **Yes** ☐ **Occasionally**

Do you drink alcohol? ☐ **No** ☐ **Yes** ☐ **Occasionally**

Are you currently taking any medication(s)? ☐ **No** ☐ **Yes**

If yes, please list the medication(s) and the condition(s) for which it is being used if known:

_____

_____

Have you previously received massage therapy treatments? ☐ **No** ☐ **Yes**

If yes, were you treated ☐ by a BC RMT ☐ other

On the below scale of 1 – 5, where 5 represents total satisfaction and 1 represents little or no satisfaction, please indicate the extent of which you are currently satisfied with the following:

Physical health & fitness	5	4	3	2	1
Mental & emotional happiness	5	4	3	2	1
Energy level	5	4	3	2	1
Diet	5	4	3	2	1
Ability to relax	5	4	3	2	1

_____ _____

Signature Date