Total Health Clinic

Confidential Patient History Form

Name _____

Address_____

City _____**Postal Code** _____

Phone (Home) _____

(Cell) _____

(Work) _____

Email _____

Occupation_____

Birthdate _____
(Month/Day/Year)

Family Doctor _____

Phone # _____

Referring Professional_____

Phone # _____

Care Card # _____

ICBC or WCB? ☐ NO ☐ YES Claim #_____

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)

_ Heart Attack
_ High/Low Blood Pressure
_ Stroke or Aneurysm
_ Pace Maker
_ Other Heart Conditions
_ Varicose Veins
_ Other Circulatory Cond
_ Diabetes
_ Kidney Disease
_ Other Urinary Condition
_ Irritable Bowel / Colitis
_ Skin Condition
_ Bruise Easily

_ Headaches / Migraines
_ Dizziness / Faintness
_ Nausea
_ Spinal Injury
_ Head Injury
_ Epilepsy / other Seizures
_ Other Neurological Condition
_ Asthma
_ Chronic Sinusitis
_ Other Respiratory Condition
_ Digestive Conditions
_ Other Contagious Condition_____

_ Joint Dislocation
_ Bone Fracture
_ Arthritis
_ Osteoporosis
_ Rods/Pins/Plates/Shunts
_ Implants _____
_ Transplant _____
_ Corrective Lenses / Contacts
_ Cancer _____
_ Hepatitis
_ HIV

Please list any Medications you presently take: _____

_____

Known Allergies: (including medications, foods, seasonal, oils and lotions, etc.)

_____

Do you have a history of medical conditions? ☐ No ☐ Yes

Please List: _____

Have you ever been hospitalized, had any major accidents, illnesses or surgeries? ☐ No ☐ Yes

Please Comment: _____

_____

Continued over …

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

☐ **Massage Therapy**	**Date of Visit**	_____	**Location**	_____
☐ **Chiropractor**	"	_____	"	_____
☐ **Physiotherapy**	"	_____	"	_____
☐ **Naturopath**	"	_____	"	_____
☐ **Acupuncture**	"	_____	"	_____
☐ **Other** _____	"	_____	"	_____

List any Activities, Sports, Hobbies
(ie. Jogging, hockey, crafts, computers, 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 indicate your current conditions/symptoms:

_____
_____
_____

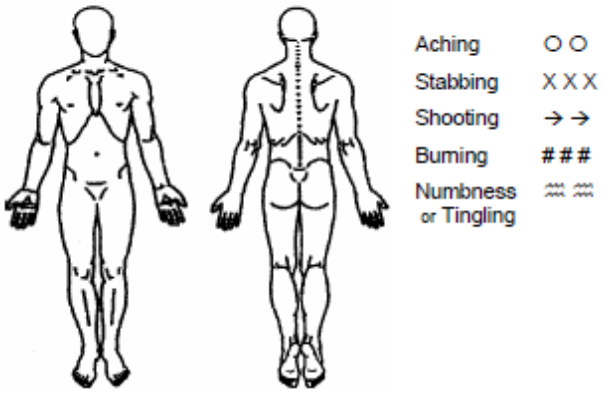
How long have you had this condition? _____

How did it start? _____
_____

What aggravates it? _____
_____

What relieves it? _____
_____

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



Please note: Your appointment time has been reserved for you. In courtesy of your therapists and fellow patients, we ask that you provide us **with 24 hours notice of cancellation or a cancellation fee will be charged**. Payment for all treatments, 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 number 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 :** _____