Marissa's Massage Therapy

Confidential Patient History Form

Name: _____

Address:_____
_____

Phone (home):_____
(cell):_____

Email: _____

Occupation: _____

Birthdate: _____

Doctor's Name: _____
Phone: _____

Referring Professional: _____

Please only complete this section if you have an open ICBC or WCB claim
Please check: ICBC ☐ WCB ☐ **Claim number**: _____
Care Card Number: _____ **Date of Injury**: _____

How did you hear about (Registered) Massage Therapy:_____
How did you hear about this 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
- ☐ **Anxiety**
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ other Urinary condition

- ☐ Headaches / Migraines
- ☐ Dizziness / Fainting
- ☐ Nausea
- ☐ Spinal Injury
- ☐ Head Injury
- ☐ Epilepsy / other seizures
- ☐ other Neurological condition
- ☐ **Depression**
- ☐ 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 currently take: _____
_____

Please list any know allergies (including medications, foods, seasonal, oils and lotions, etc):
_____

Have you ever been hospitalized for major accidents, illness, or injuries? Please comment:
_____
_____

Number of times you exercise per week: _____ **Please list any hobbies, sports, or activities**:

_____

Have you tried massage therapy before? Did you find it helpful? _____

_____

Number of hours of sleep per night_____ Sleeping position_____

Do you sleep well? Please comment: _____

Please CIRCLE the answer closest to how you PRESENTLY feel: (1 = poor, 5 = excellent)

Energy Level: 1 2 3 4 5 Stress Level: 1 2 3 4 5

Eating Habits: 1 2 3 4 5 Exercise Habits: 1 2 3 4 5

Please describe your current symptoms: _____

_____

How long have you had this condition: _____

How did this condition start:

_____

_____

What aggravates it:

_____

_____

What relieves it:

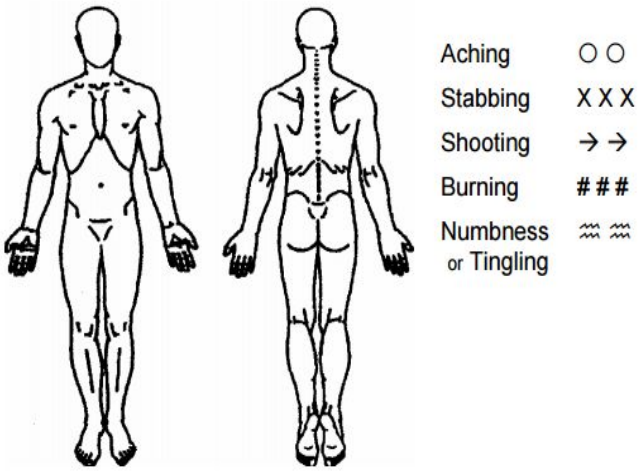
_____

_____

Please circle your current pain level:
(1 = low, 10 = high)

1 2 3 4 5 6 7 8 9 10

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



Please read this section carefully. It is important

Please make sure you discuss any questions you may have about this form or your treatment with your RMT before you sign this document.

While your RMT will keep you informed of the purpose and nature of your treatment, please remember that you have the right at any time to ask questions about your treatment, including ending your treatment, at any time.

If you are uncomfortable with any treatment or procedure, please ensure that you immediately advise the RMT of that fact. They will stop treatment and discuss it with you.

I authorize and consent to the RMT performing the following specific Massage Therapy treatments or procedures on me: soft tissue mobilization, joint mobilization, exercise therapy, other

Patient Initials: _____

I acknowledge and confirm that there are risks associated with any manual therapy techniques, including those techniques used by Registered Massage Therapists. Examples include bruising, aching & discomfort, short term aggravation of symptoms, muscle and ligament strains or sprains and skin irritation. I have discussed any concerns I have about possible risks with my Therapist before signing this document.

Patient Initials: _____

I acknowledge and confirm that I do not expect the RMT to be able to anticipate and explain all possible risks, complications and side effects of my treatments to me. I wish to rely on the RMT to exercise their judgment during the course of the treatment to provide the treatment that is in my best interest.

Patient Initials: _____

I acknowledge and confirm that:

a. I understand that it is imperative that the RMT be informed by me of my existing medical conditions and my prior medical history.

b. I have disclosed to the RMT in writing all medical conditions currently affecting me and all those that have affected me in the past.

c. If I later remember that I have failed to disclose any medical fact that I will do so immediately, and prior to my next treatment.

d. I will immediately advise the RMT of any new medical condition that may arise after I have completed this form but while I am still receiving treatment from the RMT.

e. The information regarding my medical conditions and history is true and complete to the best of my knowledge.

Patient Initials: _____

I understand that the details of this treatment and my medical history will be kept confidential unless I have expressly or implied consented to the release of my information or where there is a legal requirement to provide my information to a third party

Patient Initials: _____

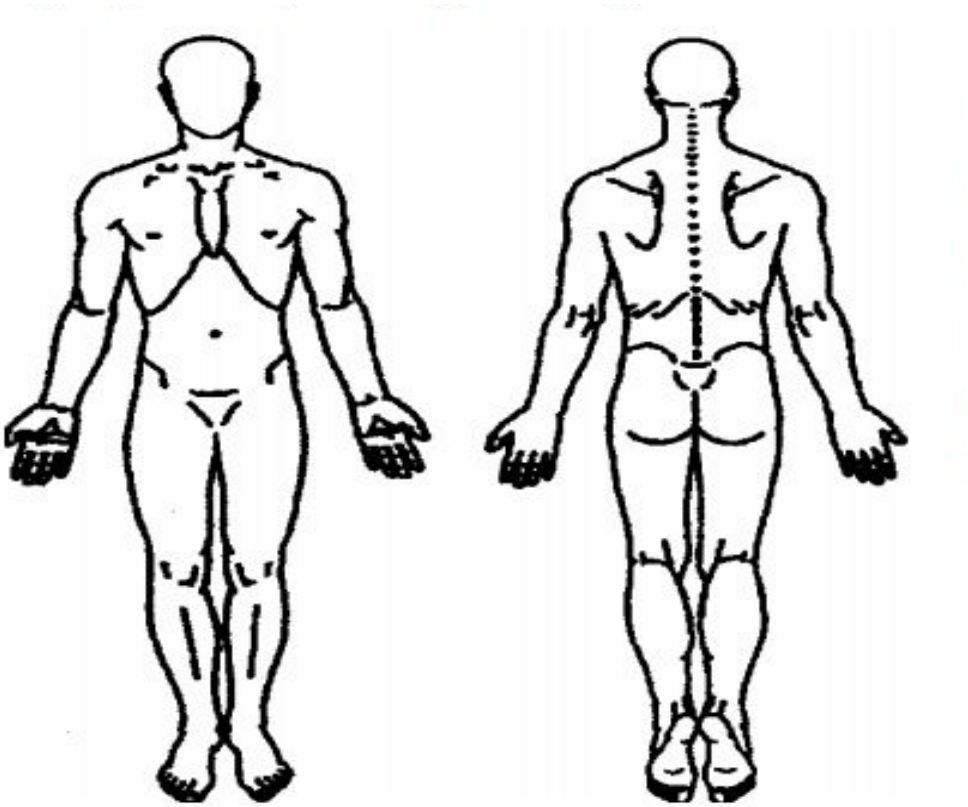
I acknowledge and confirm that no guarantee or assurance of results has been made to me regarding this treatment(s).

Patient Initials: _____

I understand that if I cancel an appointment, it takes time for the RMT to re-book that time with another patient. Accordingly, I agree to provide the RMT with a minimum of 24 hours notice (or one clear business day, whichever is longer) if I cancel an appointment. Late cancellations or missed appointments will result in a cancellation fee toward the next treatment.

Patient Initials: _____

Please circle the areas that you consent to be touched by the RMT during the treatment



I acknowledge and confirm that:

a. I have read and fully understand the contents of this consent to treatment form;

b. The explanations referred to above were in fact made to me in person as indicated above;

c. I executed this form before any treatment was provided to me by the RMT;

d. I was provided the opportunity to ask questions about the explanations and other information given to me;

e. I have no unanswered questions at the time of signing this form; and

f. I consent to the above treatment(s) on the conditions set out in this form.

Date: _____Patient Signature: _____