Update 1 _____
Update 2 _____

Confidential Medical Case History Form

Date_____

Name_____ Birth Date____(m)____(d)____(y)

Address_____City_____Postal Code_____

Home_____Cell_____Work_____

Email _____ How did you hear about us? _____

Doctor _____Occupation _____

Are you presently involved in an ICBC or WCB claim/litigation? Yes No

Claim# _____ Date of Accident: _____

What Condition or Reason do you seek treatment today?

_____

What makes it worse? _____

What makes it better? _____

Have you had this condition in the past? Yes No Was it resolved? Yes No

Medications you are currently taking:

_____

Surgeries, major injuries or accidents you have had:

_____

Do you have any internal wires, artificial joints, pacemakers or special equipment we should be aware of? _____

Are you also seeking: Chiropractor Physiotherapy Naturopath Other

Please turn over

Stress Level:	None	Slight	Moderate	Severe
Quantity of Sleep:	None	2-4hrs	5-7hrs	8-12hrs
Physical Activity:	None	Low	Moderate	High

Please indicate if any of the following apply to you: (p = past) or (c = current) and Circle or Check

__Headaches	__High/Low Blood Pressure	__Osteoporosis
__Migraines	__Loss of sensation/tingling	__Pregnancy
__Dizziness	__Heart Conditions	__Gastrointestinal Problems
__Fainting	__Heart stroke/CVA	__Constipation
__Anxiety	__Varicose Veins/Phlebitis	__Diabetes
__Eye/Visual problems	__Bruise Easily	__Menstrual Difficulties
__Ear/Hearing problems	__Chronic Cough	__Skin Conditions
__Arthritis	__Shortness of Breath	__HIV/AIDS
__Muscles Spasms	__Bronchitis	__Hepatitis
__Muscle Cramps	__Asthma	__Cancer
__Muscle Tension	__Emphysema	__Tumour/Cysts
__Muscle Strain	__Fracture/Dislocations	__Epilepsy
__Sprains	__Spinal Injuries	__Allergies

Do you have any medical conditions not listed above?

_____

Your appointment has been reserved for you. In courtesy of your therapist and fellow patients, we ask you that you provide us with **24 hours notice** of cancellation or a **cancellation fee will be charged of the full amount.** Please note we cannot bill MSP or ICBC for missed appointments.

I acknowledge and understand that the Registered Massage Therapist must be fully aware of my existing medical conditions. I have completed my medical history form to the best of my ability and knowledge. It is my responsibility to keep the Registered Massage Therapist updated on my medical history.

I authorize the collection, use and disclosure of personal information, as defined in the *Personal Information and Protection Act* (PIPA), required for treatment and/or any related administrative purpose. I understand that all my personal information is confidential, and must be treated in accordance with PIPA.

Signature _____ Date _____

Name of Guardian if patient is a child _____

Registered Massage Therapist Signature _____