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Personal Health Information (Confidential)

Name: _____ Birthdate (dd/mm/yy): _____
Care Card # or Service #: _____ Do you have extended benefits? _____
Home Number: _____ Work Number: _____ Cell Number: _____
Home Address: _____ Postal Code _____
E-mail Address: _____
Your Occupation: _____ Work Stress Level(1-10) _____
Doctor's Name: _____ Doctor's Phone Number: _____
Referred By (Friend, Doctor, Yellow Pages): _____
Chief Complaint: _____
Have you ever had massage treatment before (if yes when): _____
Current Medications (Name and for what): _____
Are you presently being treated by chiro./physio./acupuncture: _____
Headaches _____ If yes, how often _____ per week and are tension/migraine located forehead/
temple/back of neck (please circle)

Health History: (circle past / check present)

| | | | |
|-----------------|------------------|---------------------|-----------------|
| Bruise easily | Constipation | Menstrual Problems | Allergies |
| Vision problems | Insomnia | Menopause Problems | Short of breath |
| Contact lenses | Depression | Endometriosis | Asthma |
| Earaches | PID | Low blood pressure | Smoking |
| Jaw pain | Herpes | High blood pressure | Sinus infection |
| Dizziness | Other infections | Kidney problems | Arthritis |
| Sensitive skin | HIV | Heart disease | Osteoporosis |
| CFS | TB | Diabetes | Whiplash |
| Fibromyalgia | Hepatitis | Poor circulation | Chronic cough |
| Poor appetite | Pregnant now | Stroke | |

Other health issues: _____

Pain:

Where does it hurt: _____ When did it start: _____
Pain onset (describe gradually, suddenly, etc): _____
Describe the pain (sharp, dull, achy, drilling): _____
What makes it better: _____
What makes it worse: _____

PLEASE TURN OVER



Arthritis: Where: _____

Diagnosed when: _____

Cancer:

Previously or Current?

If yes, please explain: _____

Muscular/Joint Problems:

Current Pain

Previous Pain

Neck

Upper Back

Mid Back

Low Back

Shoulders

Arms

Legs

Hands

Feet

List all major injuries and treatments received: _____

List of all major surgeries (year and what for): _____

Do you have any pins, plates, or artificial joints: _____

Any information you would like me to know? _____

What are your goals/expectations from massage therapy treatments? _____

CANCELLATION POLICY: 24 HOURS NOTICE REQUIRED! Full payment required for late cancellations or missed appointments, fee payable before the next treatment.

FEE POLICY: I understand and agree that the cost of treatment is my responsibility, should private insurers, MSP, ICBC, DVA, WCB or other providers fail to reimburse the clinic for services provided. All outstanding accounts over 60 days are overdue and will be charged interest at the rate of 24% per annum.

PRIVATE STATEMENT: With my signature below I authorize the collection use and disclosure of personal information, as defined in the Personal Information and Privacy Act (PIPA). As is required for treatment or and related administrative purpose. I understand that all my personal information is confidential and must be treated in accordance with the PIPA.

Signature _____ Date _____