

**Confidential Patient History Form for
Registered Massage Therapy**

Name _____
Date of Birth _____
(month / day / year)

Occupation _____
Phone (H) _____
(W) _____
(C) _____

Mailing Address

Preferred location of contact:

Postal Code _____

E-mail _____

Care Card _____

Referring Doctor _____

How did you hear about Burnaby Heights Integrative HealthCare?

Why are you seeking Massage Therapy today?

Are you currently involved in an active ICBC or WCB claim? Yes No

Please answer the following questions about your current condition and symptoms:

Describe your current condition: _____

Is this new for you? _____ If not, how often have you experienced this? _____

How did it start? _____ When did it start? _____

What is your current level of discomfort? Slight 1 2 3 4 5 6 7 8 9 10 Severe N/A

What is your discomfort at its worst? Slight 1 2 3 4 5 6 7 8 9 10 Severe N/A

Approximately when was it last at its worst? _____

Is there a time during the day when your symptoms are worse? _____

What do you do to try to alleviate your condition? _____

Does it work for you? _____ What makes it worse? _____

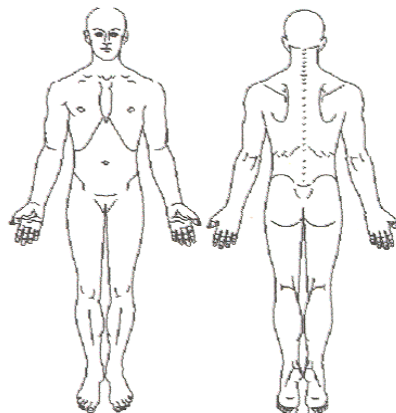
If any, what medications are you taking for your condition? _____

Have you received a diagnosis from a doctor? _____

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

List any Activities, Sports, Hobbies
(ie. Jogging, Hockey, Crafts, Computer, etc)

- Aching ○
- Stabbing X
- Shooting →
- Burning #
- Numbness or Tingling ~~~



Please indicate with a **C** for **Current** and **P** for **Past** conditions that you have or had:

- | | | | |
|----------------------------------------------|----------------------------------------|------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Bruising | <input type="checkbox"/> Crohns/Colitis |
| <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Weakness | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Concussions | <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Fatigue | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> MS |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Dislocations | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Skin conditions | <input type="checkbox"/> Anxiety |

Are you satisfied with your current: (1 = not at all, 5 = completely satisfied)

- | | | | |
|-------------------|-----------|--------------------------------------------------|-------|
| Ability to work | 1 2 3 4 5 | Hours of sleep per night (approx.) | _____ |
| Level of exercise | 1 2 3 4 5 | Number of meals you regularly eat per day | _____ |
| Diet | 1 2 3 4 5 | Number of times you exercise per week | _____ |
| Sleeping patterns | 1 2 3 4 5 | | |
| Energy level | 1 2 3 4 5 | | |
| Emotional status | 1 2 3 4 5 | | |

Do you:

- | | | | | |
|--------------------------|------|------|-------------------|-------|
| Wear orthotics? | Yes | No | If yes, what for? | _____ |
| Wear a dental appliance? | Yes | No | If yes, what for? | _____ |
| Sleep on your | Back | Side | Stomach | |

Please list any **major accidents, illnesses or medical procedures.**

Do you take any **medications, herbal supplements or vitamins/minerals?**

- | | |
|--------------|---------|
| Please list: | Reason: |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Are you currently receiving treatment from any of the following health professionals?

Doctor____ Naturopath____ Chiropractor____ Physiotherapist____ Acupuncturist____

Have you had massage therapy before? _____ If yes, when? _____

What for? _____

Please Note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with **24 hours** notice of cancellation, or the appointment fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

I give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above.

The information on this form is correct to the best of my knowledge and provides an accurate summary of my past and present medical status. I hereby give my consent to receive massage therapy at Burnaby Heights Integrative HealthCare Inc. and I assume the financial responsibility for all treatments I receive.

Patient (or guardian) signature _____ **Date:** _____