

**CONFIDENTIAL PATIENT HISTORY FORM**



SAFE, SMART, EFFECTIVE HEALTH CARE

Delbrook Massage Therapy Clinic  
 100-3711 Delbrook Avenue  
 North Vancouver, BC, V7N 3Z4  
 604.986.9191  
 Anne-Marie Côté, RMT, Peter Maharajh RMT

**Name** \_\_\_\_\_

**Birthdate** \_\_\_\_\_  
 (month / day / year)

**Address** \_\_\_\_\_

**Family Doctor** \_\_\_\_\_

Phone \_\_\_\_\_

**Postal Code** \_\_\_\_\_

**Referred by** \_\_\_\_\_

**Phone** (home) \_\_\_\_\_

(cell) \_\_\_\_\_

(work) \_\_\_\_\_

**Email** \_\_\_\_\_

**Occupation** \_\_\_\_\_

**Care Card #** \_\_\_\_\_

**ICBC or WCB?**    **No**    **Yes**    Claim# \_\_\_\_\_

(if active claim, please inform RMT as you will need to fill out the related Claim Form)

**How did you hear about our clinic?** \_\_\_\_\_

**Please indicate if you believe if any of the following apply to you? (P = past C = current) Circle if necessary.**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Heart Attack                | <input type="checkbox"/> Headaches / Migraines        | <input type="checkbox"/> Joint Dislocation             |
| <input type="checkbox"/> High / Low Blood Pressure   | <input type="checkbox"/> Dizziness / Fainting         | <input type="checkbox"/> Bone Fracture                 |
| <input type="checkbox"/> Stroke or Aneurysm          | <input type="checkbox"/> Nausea                       | <input type="checkbox"/> Arthritis                     |
| <input type="checkbox"/> Pace Maker                  | <input type="checkbox"/> Spinal Injury                | <input type="checkbox"/> Osteoporosis                  |
| <input type="checkbox"/> other Heart condition       | <input type="checkbox"/> Head Injury                  | <input type="checkbox"/> Rods / Pins / Plates / Shunts |
| <input type="checkbox"/> Varicose Veins              | <input type="checkbox"/> Epilepsy / other seizures    | <input type="checkbox"/> Implants _____                |
| <input type="checkbox"/> Bruise easily               | <input type="checkbox"/> other Neurological condition | <input type="checkbox"/> Transplant _____              |
| <input type="checkbox"/> other Circulatory condition |   | <input type="checkbox"/> Corrective Lenses/Contacts    |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Cancer _____                  |
| <input type="checkbox"/> Kidney Disease              | <input type="checkbox"/> Chronic Sinusitis            | <input type="checkbox"/> Hepatitis                     |
| <input type="checkbox"/> other Urinary condition     | <input type="checkbox"/> other Respiratory condition  | <input type="checkbox"/> HIV                           |
|  | <input type="checkbox"/> Irritable Bowel / Colitis    | <input type="checkbox"/> other Contagious condition    |
|  | <input type="checkbox"/> Digestive condition          |  |
|  | <input type="checkbox"/> Skin condition               |  |

**Please list any Medications you presently take:**

\_\_\_\_\_  
 \_\_\_\_\_

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

\_\_\_\_\_

**Do you have any family history of medical conditions?**    **Yes**                      **No**

Please list: \_\_\_\_\_

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

Please comment: \_\_\_\_\_

\_\_\_\_\_

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

Massage Therapy	Date of last visit	_____	Location	_____
Chiropractor	"	_____	"	_____
Physiotherapy	"	_____	"	_____
Naturopath	"	_____	"	_____
Acupuncture	"	_____	"	_____
Other _____	"	_____	"	_____

**List any Activities, Sports, Hobbies**  
(ie. Jogging, Hockey, Crafts, Computer, 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	<b>Hours of sleep per night</b> (approx.)	_____
Energy Level	1	2	3	4	5	<b>Number of meals you regularly eat per day</b>	_____
Eating Habits	1	2	3	4	5	<b>Number of times you exercise per week</b>	_____
Stress Level	1	2	3	4	5		
Exercise Habits	1	2	3	4	5		

Smoker	Yes	No	Occasional
Alcohol	Yes	No	Occasional

**Current Condition**

Please describe your current condition & symptoms: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

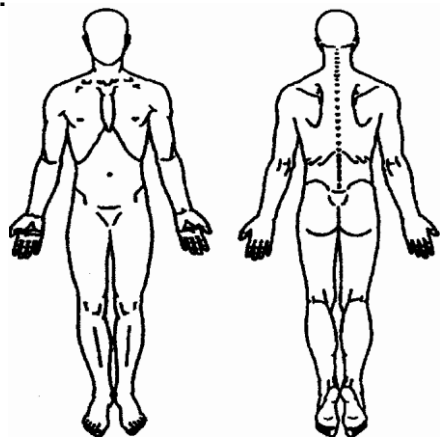
How long have you had this condition? \_\_\_\_\_

How did it start? \_\_\_\_\_

What aggravates it? \_\_\_\_\_

What relieves it? \_\_\_\_\_

**Please indicate on the diagram the area of your symptoms:**



**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 full fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

\_\_\_\_ **Sharing of My Patient Record:** My initials confirm that I request and authorize my RMT to provide to the Clinic and to other health care practitioners who provide me with treatment, copies of any patient record created by my RMT. I understand this will enable the Clinic to maintain a complete patient record on my behalf. I understand that I may revoke this permission in writing at any time in the future.

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 numbers 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 the clinic will maintain a complete record on my behalf. I understand that my records will only leave the clinic or be disclosed to third parties with my permission.

**Signature:**

**Date:**