Alive and Well
Massage Therapy Clinic
790 Seymour St Kamloops BC V2C 2H3
250-374-6325
www.AliveAndWellMassageTherapy.ca

CONFIDENTIAL PATIENT HISTORY FORM

Name _____ **Today's Date** _____
(month / day / year)

Address _____

_____ **Birthdate** _____
(month / day / year)

Postal Code _____

Email _____ **Occupation** _____

Phone (home) _____ **Care Card #** _____
(cell) _____ **Referring MD** _____
(work) _____ **Claim #** _____

How did you hear about our clinic? (please be specific)_____

Current Condition (or areas that your are requesting massage therapy for)

Please describe your current condition & symptoms: _____

_____

_____

_____

How long have you had this condition? _____

_____

How did it start? _____

_____

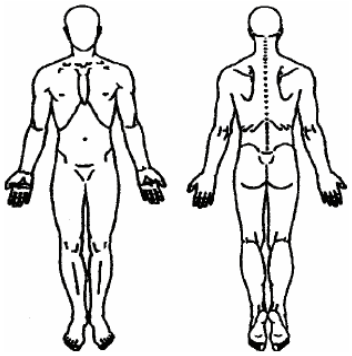
What aggravates it? _____

_____

What relieves it? _____

_____

On the diagram, please indicate all areas of concern:



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

☐ Registered Massage Therapy ☐ Chiropractics ☐ Physiotherapy ☐ Naturopathy ☐ Acupuncture
☐ Other _____

Please list any medications you presently take:

_____

_____

Known Allergies: (including medications, foods, seasonal/environmental, oils and lotions, etc.)

_____

_____

List any **Non-prescription vitamins, minerals, or other supplements** you are taking:

_____

_____

_____

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

_____

_____

_____

Continued over…

Please CIRCLE how you feel CURRENTLY about your: (1 = very dissatisfied, 5 = very satisfied)

Pain Levels	**1**	**2**	**3**	**4**	**5**
Stress Levels	**1**	**2**	**3**	**4**	**5**
Energy Levels	**1**	**2**	**3**	**4**	**5**
Quality of Sleep	**1**	**2**	**3**	**4**	**5**
Eating Habits	**1**	**2**	**3**	**4**	**5**
Exercise Habits	**1**	**2**	**3**	**4**	**5**

Please estimate approximately on the following:

Hours of **sleep** per night: _____

Number of glass of **water** per day: _____

Number of times you **exercise** per week: _____

Number of times you **stretch** per week: _____

Please indicate if any of the following apply to you: (P = past C = current) Circle if necessary

__ Heart Attack
__ High / Low blood pressure
__ Stroke / Aneurysm
__ Pace maker
__ Other heart condition

__ Varicose Veins
__ Bruise easily
__ Lymphedema
__ Diabetes
__ Other circulatory condition

__ Kidney disease
__ Other Urinary condition

__ Painful breasts
__ Painful menstruation
__ Pregnancy

__ Headaches / Migraines
__ Dizziness / Fainting
__ Nausea
__ Mental illness / Depression
__ Spinal Injury
__ Head Injury
__ Epilepsy / other seizures
__ Other neurological condition
__ Corrective lenses / Contacts

__ Asthma
__ Sinus problems
__ Other respiratory condition

__ Irritable bowel / Colitis
__ Other digestive condition

__ Skin condition

__ Joint dislocation
__ Ligament sprain
__ Muscle strain
__ Jaw problems / TMJ
__ Bone fracture
__ Arthritis
__ Disc problems
__ Osteoporosis
__ Rods / Pins / Plates / Shunts
__ Implants / Transplant

__ Cancer
__ Hepatitis
__ HIV
__ Other contagious condition

__ Fever
__ Other:_____

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

Please comment: _____

Please READ, sign, and date.

Payment Policy:

I understand that I am ultimately responsible for the full cost of my appointments, including any event where my insurance company (eg. ICBC, MSP, DVA, RCMP) should deny their payment portion to the Registered Massage Therapists (RMTs). Payment is due at time of service. _____**Please Initial**

Cancellation/Missed Appointment Policy:

I understand that 24-hours notice is required to cancel or change any appointment. If I miss my appointment, or cancel, or change it, without 24-hours notice, I will be responsible for the **full cost** of that appointment.

(We thank you for respecting your time, our time, and that of fellow patients.) _____**Please Initial**

Consent:

I hereby assume all responsibility to communicate any discomfort or pain during any point in the treatment, releasing any and all liability or responsibility of the Registered Massage Therapist (RMT).

The RMTs of Alive and Well Massage Therapy Clinic may:

-contact me and leave messages for me regarding appointments at any of the contact info I have provided;

-provide me with massage therapy treatments. _____**Please Initial**

Signature: _____ **Date:** _____