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

CONFIDENTIAL PATIENT HISTORY FORM

Today's Date: _____

Name _____ **Birthdate** _____
Address _____ (month / day / year)
_____ **Gender** _____
Postal Code _____ **Phone** home _____
Email _____ cell _____
Occupation _____ work _____

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

Please describe your current condition & symptoms: _____

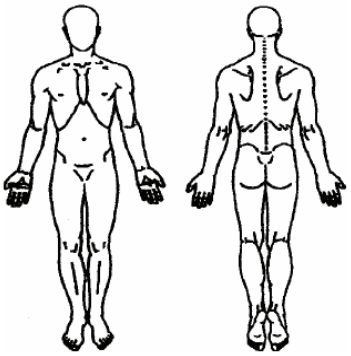
How long have you had this condition? _____

How did it start? _____

What aggravates it? _____

What relieves it? _____

On the diagram, please indicate all areas of concern:



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

__ 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
__ Menopause
__ Skin condition
__ Headaches / Migraines
__ Dizziness / Fainting
__ Nausea
__ Mental illness
__ Anxiety / Depression
__ PTSD
__ Sleep Disorder
__ Spinal Injury
__ Bain / Head Injury
__ Epilepsy / other seizures
__ Other neurological condition
__ Corrective lenses / Contacts
__ Asthma
__ Sinus problems
__ Other respiratory condition
__ Irritable bowel / Colitis
__ Other digestive condition
__ Joint dislocation
__ Ligament sprain
__ Muscle strain
__ Jaw problems / TMJ
__ Bone fracture
__ Arthritis
__ Disc problems
__ Osteoporosis
__ Rods / Pins / Plates / Shunts
__ Implants / Transplant
__ Cancer
__ Immunocompromised condition
__ Contagious condition
__ Chronic Pain
__ Fever
__ Other:_____

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

Continued over…

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

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

List any medications, supplements, vitamins, minerals, you presently take:

_____

_____

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

_____

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

_____

_____

Please READ and WAIT to sign this portion with your RMT

Payment Policy:
I understand that I am ultimately responsible for the **full cost** of my appointments, including any event where my insurance company (e.g. MSP, VAC, RCMP, Blue Cross, etc.) should deny their payment portion to the Registered Massage Therapist (RMT). Payment is due at time of service.

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.)

Contact & Health Care Record Policy:
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;
-review any part of my Health Care Record/File at the clinic to enable continuity of my treatment plan.

Consent to Treatment:
I fully consent to _____, RMT performing the following treatment:
1. Massage Therapy, as defined by the scope of practice for RMTs, regulated by the College of Massage Therapists of British Columbia under the BC Health Professions Act.
2. The specific treatment planned laid out today.

I understand the treatment and procedure, the risks involved and the possibility of complications.
I am aware that I can revoke my consent or ask for a change to the treatment plan at any time.
I have also had an opportunity to ask questions about its content and, by signing below,
I agree to the above named procedure by the Practitioner.

Signature: _____ Date: _____

Name: _____ Guardian/Representative: _____