Confidential Patient History Form

Name: ……
Birthdate:……
Address: ……
Family Doctor:……
Referring Professional:…….

Phone (Home)…….(Cell)……(Work)……
E mail……..
Occupation:…….
Care Card #.....
Extended Medical Insurer…….
IBC or WCB no yes
How did you hear about (registered) Massage Therapy?.....
How did you hear about our clinic?.....

Please indicate if you believe if any of the following apply to you?
(P=past, C=current)

Heart Attack	Headache/Migraines	Joint Dislocation
High/Low Blood pressure	Dizziness/Fainting	Bone Fracture
Stroke or Aneurysm	Nausea	Arthritis
Pacemaker	Spinal Injury	Osteoporosis
Other Heart Conditions	Head Injury	Rods/Pins/Plates
Varicose Veins	Epilepsy/Other Seizures	Implants
Bruise Easily	Other Neurological Conditions	Transplant
Other Circulatory Conditions		Corrective Lenses
Diabetes	Asthma	Cancer
Kidney Disease	Chronic Sinusitis	Hepatitis
Other Urinary Conditions	Other Respiratory Conditions	HIV
	Irritable Bowel/Colitis	
	Digestive Condition	
	Skin Condition	

Please list any Medications you presently taken:

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

Do you know any family history of medical conditions? Yes. No.

Please list:

Have you ever. Been hospitalized, had any major accidents, illness, or surgeries? Yes. No.
Please comment:

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

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

List any Activities, Sports, Hobbies:

List and 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
Energy Level	1	2	3	4	5
Eating habits	1	2	3	4	5
Stress level.	1	2	3	4	5
Exercise habits	1	2	3	4	5

Smoker	Yes	No	Occasional	(Please circle)
Alcohol	Yes	No	Occasional	

Current Condition
Please describe your current conditions & symptoms:

Please indicate on the Digram the nature of your Symptoms, using the symbols:

How long have you had this condition?
How did it start?

What aggravates it?

What relieves it?

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 a cancel fee will be charged. Payment for all treatment, whether private or insured, s ultimately the responsibility of the patient.

I authorize the clinic and its associated RMT's to collect 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 umbers 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 will only be disclosed to third parties with my permission.

Signature:……..

Date:……

Consent to Treatment

Patient
Name:……

- Read this document, including Schedule "A", carefully and completely. Its most important.
- Lease be sure to ask your RMT any questions you have about this from or its consent BEFORE you sign this document.
- You have the right at any time to ask questions about our treatment.
- Please be sure to immediately advise your RMT if you become uncomfortable with any aspect of your treatment, so they may stop and discuss it with you.

The treatment: I authorize and consent to theRMT performing the following specific treatments on me:

Soft tissue mobilization. Joint mobilization Exercise therapy
Other:

Risks, Complications & side effects: I acknowledge and understand that:

- There are risks associated with any manual therapy techniques, including those techniques used by Registered massage therapist. Examples include bruising, aching, discomfort, short term aggravation of symptoms, muscle and ligament strains, sprains and skin irritation;
- I have discussed any specific concerns I have about possible e risks with my therapist before signing this document;
- The nature and purpose of the above treatments, the possible alternative methods of treatment, the risks involved and the possible complications and side effects have been fully explained to me by my RMT;

- I do not expect the RMT to be able to anticipate and explain all possible risks , complications and side effects of my treatment(s) to me;
- I wish to rely on the RMT to exercise their judgment during the course of the treatment to provide the treatment that is in my best interests.

Disclosure of Medical History: I acknowledge and understand that:

- It is important for the RMT to know my medical history as it may relate to my treatments(s);
- I have disclosed to the RMT in writing all medical conditions, including any medical or emotional conditions for which I have received treatment, currently affecting me and those that have affected me in the past;
- I will immediately disclose in writing and medical condition that I subsequently realize I have not already disclosed, including any new condition that may develop after my completion of this form;
- the information disclosed by me is true and complete to the best of my knowledge.

Confidentiality: The contents of this form and my patient records will be kept confidential unless I have expressly or impliedly consented to the release of my information or where there is a legal requirement to provide my information to a third party.

No guarantee of result: I acknowledge and confirm that no guarantee or assurance of result has been made to me regarding my treatments.

Signature of patient* Date:(dd/mm/yy)
(*in the case of a person incapable of providing consent, signature of Parent or Guardian, in which case the Name & Relationship of Person signing:)

Schedule A

To consent to treatment of:

(Patient name)……

Dated (dd/mm/yy) __/__/__

Body areas to be treated:

I acknowledge and confirm that the areas of my body circled on the diagram will be touched by the RMT during the course of my treatment.

I acknowledge and understand that it may be necessary for the RMT to adjust their treatment plan during my treatment, in which case they will discuss that with me.

Signature of Patient*: ……

Date (dd/mm/yy); __/__/__

(*in the case of a person incapable of providing consent, signature or guardian, in which cases the name 7 relationship of person signing: