**DOMINELLI MASSAGE THERAPY & WELLNESS**

# CONFIDENTIAL PATIENT HISTORY FORM

Name _____ Birthdate _____

Address _____ Family Doctor _____
City _____ Phone _____
Postal Code _____ Referring Professional _____
Phone _____

Phone (Home) _____ Care Card # _____
(Cell) _____ Extended Medical Insurer _____
(Work) _____ ICBC or WCB? No Yes Claim# _____
E-mail _____ If active claim, please inform RMT as you will need to fill out the related Claim Form)
Occupation _____

How did you hear of this clinic? Name _____
□ Friend/Relative □ Referred by Doctor/Chiropractor □ Walking by □ Referred by Physio/Trainer
□ Other (please specify)_____

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

- Heart Attack
- High / Low Blood Pressure
- Stroke or Aneurysm
- Pace Maker
- Other heart condition
- Varicose Veins
- Bruise easily
- Other Circulatory condition.
- Diabetes
- Kidney Disease
- Other Urinary condition.
- Hemophilia
- Headaches / Migraines
- Dizziness / Fainting
- Nausea
- Spinal injury
- Head injury
- Epilepsy / other seizures
- Other Neurological condition.
- Asthma
- Chronic Sinusitis
- Other Respiratory condition
- Irritable Bowel / Colitis
- Digestive condition
- Skin condition
- Joint Dislocation
- Bone Fracture
- Arthritis
- Osteoporosis
- Rods / pins / plates /shunts
- Implants _____
- Transplant_____
- Corrective Lenses/Contacts.
- Cancer
- Hepatitis
- HIV
- Other Contagious condition _____
- Pregnancy

Have you ever been hospitalized, had any major accidents, illnesses, or surgeries? ____Yes ____No
Please comment _____

Continued over…

Since January 1st have you visited any of the following? (Please check all that apply)
□ Chiropractor □ Massage Therapist □ Naturopath □ Physiotherapist □ Podiatrist

How many visits have you had since January 1st? _____

Please list any Medications you presently take:

_____
_____

Known Allergies:

_____
_____

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 |
| 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 |

Hours of sleep per night (approx) _____

Number of meals you regularly eat per day _____

Number of times you exercise per week _____

| | | | |
|---|---|---|---|
| Smoker | Yes | No | Occasional |
| Alcohol | Yes | No | Occasional |

## Current Condition

Please describe your current condition & symptoms

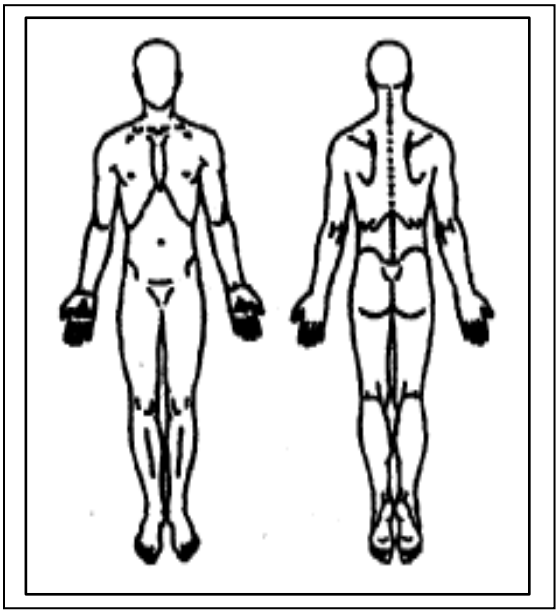
_____
_____
_____

How long have you had this condition? _____

How did it start? _____
_____

The problem / condition is: (Please circle)
○ improving ○ getting worse ○ stays the same
○ constant ○ worse in morning
○ comes and goes ○ worse in evening

Indicate areas involved



I _____ authorize the staff and therapists of this clinic to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages by phone and/or email regarding appointments using any of the contact information provided.

In addition, I _____ authorize the staff and therapists at this clinic 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**: _____

## Cancellation Policy

**To avoid a cancellation fee we require a minimum of 24 hours notice when cancelling or rescheduling an appointment.** If less than 24 hours notice is provided we will make every effort to fill the appointment, however in the event we are unable to fill the appointment a bill for the full amount of the session will be owed. In the event of a missed appointment a bill for the full amount of the session will be owed.

Please be aware that a receipt will be issued for the cancellation fee, however this cancellation fee is not reimbursable through extended benefits provided by third party insurers.

It is the responsibility of the patient to determine if their supplemental or extended health care insurance may provide coverage for massage therapy treatment. Payment for all treatments whether private or insured is ultimately the responsibility of the patient. A receipt will be issued for each payment.

_____ _____

Patient Signature Date

_____

Patient Name

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## Contact List

We would like to stay connected with you

Please provide your email address if you would like receive information regarding future promotions, events, newsletters and updates from our team at the clinic.

_____

Email Address (Optional)