Patient Intake Form

Date: _____

Please fill out our confidential Patient Health Record completely and accurately.
If you have any questions, please don't hesitate to ask your practitioner.

PERSONAL INFORMATION

Name: _____

BC Medical #: _____

Birthdate (mm/dd/yyyy): _____ /_____ / _____

Age: _____ Gender: Male ☐ Female ☐

Address: _____

City: _____ Prov: _____ Postal: _____

Occupation: _____

Home #: _____ Work #: _____

Mobile #: _____

Email: _____

Emergency Contact: _____

Phone #: _____

Did a health care practitioner refer you?

Yes ☐ No ☐

If yes, please provide the following:

Name: _____

Phone #: _____

Current Medical Practitioner: _____

Phone #: _____

Date of last physical examination? _____

Briefly describe your main concern(s):

_____

_____

Overall, how is your general health?

_____

_____

List of current medications:

_____

_____

_____

REASON(S) FOR YOUR APPOINTMENT

Is the purpose of this visit appointment related to?

☐ Job ☐ Auto Accident ☐ Fall ☐ Sports Injury
☐ Chronic Discomfort ☐ Wellness Care ☐ Other

How long have you had this condition? _____

Is your condition getting: ☐ **worse** ☐ **better** ☐ **same**

What seems to make the condition **better**?

_____

What seems to make the condition **worse**?

_____

What have you tried that has **not worked**?

_____

Is it interfering with your:

☐ Work ☐ Sleep ☐ Daily Routine ☐ Other

Have you seen a:

☐ Chiropractor ☐ Physiotherapist
☐ Massage Therapist ☐ Acupuncturist

Date of last treatment: _____

Were you happy with the results? Yes ☐ No ☐

If **NO**, why? _____

Have you seen any other physician or healthcare professional for this complaint? Yes ☐ No ☐

If **YES**, who? _____

Date of last treatment? _____

Were X-rays or any other medical testing performed?

Yes ☐ No ☐

If auto accident, are you claiming under Insurance Corp. of BC (ICBC)?

Yes ☐ No ☐

Date of Accident: _____

ICBC Claim #: _____

Adjustor's Name: _____

Phone #: _____

PLEASE COMPLETE THE FORM ON THE OTHER SIDE

HEALTH HISTORY

Please indicate conditions presently causing you problems, as well as conditions which were a problem in the past.

Musculoskeletal System	Present	Past
Neck Problems	□	□
Jaw Problems	□	□
Upper Back Problems	□	□
Shoulder Problems	□	□
Elbow/Wrist Problems	□	□
Low Back Problems	□	□
Ankle/Foot Problems	□	□
Arthritis	□	□
Muscle Soreness	□	□
Scoliosis	□	□

Circulatory System	Present	Past
High Blood Pressure	□	□
High Cholesterol	□	□
Heart Condition	□	□
Aneurysm	□	□
Stroke	□	□
Varicose Veins	□	□
Bleeding Disorder	□	□

Pulmonary	Present	Past
Asthma	□	□
Chest Pain	□	□
Difficulty Breathing	□	□
Persistent Cough	□	□

Genito-Urinary System	Present	Past
Painful Urination	□	□
Excessive Urination	□	□
Scanty Urination	□	□
Discolored Urine	□	□

Nervous System	Present	Past
Headaches	□	□
Loss of feeling	□	□
Numbness	□	□
Dizziness	□	□
Fainting	□	□
Loss of balance	□	□
Confusion	□	□
Depression	□	□
Forgetfulness	□	□
Fatigue	□	□
Anxiety	□	□

Allergies	Present	Past
Seasonal	□	□
Hay Fever	□	□
Sinus Pain	□	□
Drug	□	□
Food	□	□

Other: _____

Gastrointestinal System	Present	Past
Poor Appetite	□	□
Excessive Hunger	□	□
Abdominal Pain	□	□
Excessive Thirst	□	□
Nausea/Vomiting	□	□
Diarrhea	□	□
Constipation	□	□
Bloody/Black Stool	□	□
Liver/Gallbladder trouble	□	□
Weight Trouble	□	□
Ulcer	□	□

Systemic	Present	Past
Diabetes	□	□
Hypoglycemia	□	□
Epilepsy	□	□
Rheumatoid	□	□
TB	□	□
HIV/AIDS	□	□
Cancer: Stage: _____	□	□
MS	□	□
Parkinson's	□	□
Thyroid Problems	□	□

Other:

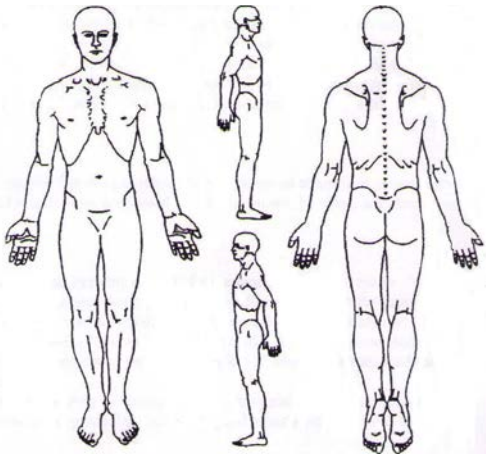
Ear, Eyes, Nose, Throat	Present	Past
Eye Problems	□	□
Vision Problems	□	□
Ear Discharge	□	□
Ear Pain	□	□
Ear Ringing	□	□
Hearing loss	□	□
Sore Throat	□	□
Hoarseness	□	□
Enlarge Glands	□	□

Female	Present	Past
Vaginal Discharge	□	□
Vaginal Bleeding	□	□
Hormonal contraceptives	□	□
Menstrual pain	□	□
Irregular cycle	□	□
Menopausal?	Yes □	No □
Pregnant?	Yes □	No □

Due Date? _____

Male	Present	Past
Prostate Problems	□	□

Mark the areas of your body with an X where you feel pain or discomfort



Orthopedic metal implants?
Yes □ No □
Explain:_____

Recent cortisone injections?
Yes □ No □
Explain:_____

Had any broken bones?
Yes □ No □
Explain:_____

Been struck unconscious?
Yes □ No □
Explain:_____

Any significant accidents or injuries?
Yes □ No □
Explain:_____

Had surgery?
Yes □ No □
Explain:_____

Had any major strains or sprains?
Yes □ No □
Explain:_____

Use orthotics, heel lifts, or insoles?
Yes □ No □
Explain:_____

Scale from 1 (not painful) to 10 (very painful); please indicate your pain level?

_____

The information on this form is true to the best of my memory and I consent to further evaluation as deemed appropriate by the Practitioner. I have agreed to receive email appointment reminders, newsletters, and other correspondence relating to my treatment(s).

<u>24 HOUR CANCELLATION FEE WILL APPLY IF PATIENT DOES NOT CALL TO CANCEL 24 HOURS PRIOR TO APPOINTMENT</u>.

Patient Initials: _____

Patient Signature: _____ Date: _____

MASSAGE THERAPY INFORMED CONSENT

I, _____, consent to having _____, RMT, performing Massage Therapy as defined by the scope of practice for RMTs regulated by the College of Massage Therapists of British Columbia under the Health Professions Act of Canada.

I understand the treatment and procedure, the risks involved and the possibility of complications. I appreciate there can be no guarantee of assurance as to results and that further treatment may be necessary. I do not expect the Practitioner to be able to anticipate and explain all risks and complications and I wish to rely on the Practitioner to exercise judgment during the course of the procedure which the Practitioner feels at the time, based on the facts known, is in my best interest.
I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I understand that massage therapy is not a substitute for a medical examination.

I have read the above consent. 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. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Signature:_____ Date:_____

If the patient is under the age of 19 years of age

I the parent/guardian of the minor patient understand and consent to the practitioner performing on my child the treatment and procedure described in the above consent.

Signature:_____ Date:_____