White Oaks Massage & Wellness
Registered Massage Therapy
1345 Johnston Road
White Rock, BC V4B 3Z3

Confidential Patient History Form

Name: ______________________ Birthdate: ______________

Address: ______________________ Cell #: ______________
Postal Code: ________

Occupation: ______________________ Home phone #: ______________

Email: ______________________ How did you hear about us? ________

ICBC Claim: Yes ☐ Claim # __________ Care Card #: ______________

Extended Health Provider: ________ Member ID#: ______ Policy #: ______

Medical History

Please list any medications you presently take: ______________________

Please list any know allergies: ______________________

Please list all major accidents and broken bones to date: ______________________

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Please list all surgeries to date: ______________________

Please list all major illnesses to date: ______________________

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Are you pregnant: Yes ☐ No ☐ If yes, how far along? ______________

Do you have any foreign bodies, ie: IUD, pacemaker, metal screws or plates, wire mesh (hernia repair) – please circle or list other(s) here: ______________________

Circle any other therapy/treatment you are presently receiving: Massage Therapy/Chiropractor/Physiotherapy Naturopath/Acupuncture/other ______________________

Please comment on level of fitness and form of activity: ______________________

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…/continued

Current Condition

Please describe your current condition and symptoms: ____________________

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How long have you had this condition? ____________________

How did it start? ____________________

Please **check** conditions you are experiencing presently and **circle** conditions you have experienced in the **past**.

Skin: ☐ Rashes ☐ Psoriasis ☐ Eczema Other ____________________

Muscular/ Joints: ☐ Weakness or loss of strength ☐ Osteoporosis/osteopenia ☐ Rheumatoid arthritis ☐ Osteoarthritis ☐ Tendonitis ☐ Sprain/strain Other ____________________

Respiratory: ☐ Asthma ☐ Bronchitis ☐ Difficulty breathing ☐ Emphysema ☐ Smoking ☐ Other ____________________

Cardiovascular: ☐ High/low blood pressure ☐ Heart attack ☐ Stroke ☐ Poor circulation Other ____________________

Head / Neck: ☐ Visual impairment ☐ Hearing impairment ☐ Speech impairment ☐ Headaches/migraines ☐ Jaw pain (TMJD) ☐ Sinus problems ☐ Concussion / post-concussion Other ____________________

GI Tract: ☐ Constipation/Diarrhea ☐ Gas ☐ Painful elimination Other ____________________

Mental Health: ☐ Depression ☐ Anxiety ☐ PTSD ☐ Dementia Other ____________________

Other: ☐ Diabetes ☐ Cancer ☐ Fainting ☐ Fever ☐ Insomnia ☐ Stress ☐ Numbness/tingling ☐ Liver / Kidney / Bladder conditions Other ____________________

Cancellation Policy and Consent for Treatment

The Therapists at this clinic run their own practices and receive their sole source of income from the treatments they provide for you. Your appointment time has been reserved especially for you. In courtesy to your therapist and fellow patients, we require that you provide us with **24 hours' notice** of any cancellation or change of appointment time. In the absence of 24 hours' notice, you will be charged the full cost of your treatment, unless we are able to fill your appointment with another client, in which case, you will not be charged.

"I authorize White Oaks Massage & Wellness and its associated RMT's to collect my 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 numbers I have provided above. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission. I understand and accept the conditions listed above outlining the White Oaks cancellation policy and I give full consent for treatment".

Signature: ____________________ Date: ____________________