401-3939 Quadra St.
Victoria, BC, V8X 1J5
250-727-2790

Confidential Personal Health Information

Name:_____
(*As it appears on your care card)*
Address: _____
_____
Phone:(Home)_____
(Cell) _____
(Work) _____
(**please indicate preferred contact #)*

Email:_____
May we contact you by email? **Y/N**
Occupation:_____
Daily tasks: _____
Family Doctor: _____
Birth Date (mm/dd/yy): _____
PHN/Care Card #:_____
Gender:_____

How did you hear about our clinic? (Please circle): - Google Search - Phone Book - Website - Phone App - Doctor Referral/Personal Referral (please name) _____
Promotional offer:_____ Other:_____

Insurance Carrier:_____ Policy #:_____ ID #:_____
Name of Policy Holder (if you are not the insured member):_____

Please list any supplements or medications you are/have recently taken and for what purpose:
_____
_____

Do you now, or have you ever, had any of the following issues: (Check past, circle present)

-Headache	-Jaw pain	-PID
-Arthritis	-Tuberculosis (TB)	-Liver problems
-Osteoporosis	-Vision problems	-Pregnancy (#___)
-Fibromyalgia (FM)	-Poor appetite	-Endometriosis
-Migraine	-Dizziness	-Herpes
-Plantar Warts	-Sinus infection	-Heart Disease
-Sensitive Skin	-Poor Circulation	-Chronic Cough
-Constipation	-High/Low Blood Pressure	-Menstrual Issues
-Asthma	-Whiplash	-Menopause
-Athlete's foot	-Bruise easily	-Mental illness
-Insomnia	-Diabetes	-Eczema
-Kidney Problems	-Shortness of breath	-Mental/Emotional Stress
-Earaches	-Smoking	-Epilepsy
-HIV/AIDS	-Hepatitis	-Varicose Veins
-Dermatitis	-Stroke	-Hearing problems
-Depression	-Chronic fatigue (CFS)	-Multiple Sclerosis (MS)

-Numbness/Loss of sensation (Where?)_____
-Chronic Pain (Where?)_____
-Allergies/Sensitivities _____
-Cancer (Please list treatments) _____
-Other _____

Please complete back side of form →

Please give a brief detailed description of the problem you are currently experiencing: _____
_____
What therapies are you currently receiving? _____
Please list any surgeries, injuries, or major accidents including the year and any lasting complications: _____
_____
Do you have any artificial pins, plates or joints?_____
_____
What goals or expectations do you have for massage therapy? _____
_____
What exercise/activities do you do regularly? _____
Is there any additional information you would like me to know? _____
_____

Is this visit for ICBC **Y/N** or WorksafeBC **Y/N**? Date of accident: _____
Claim number: _____ Adjustor's Name:_____
Employer: _____ Referring Physician: _____
Please list details of accident: _____
_____
Symptoms since accident: _____
Limitations since accident: _____
Did you go to the hospital? **Y/N**; Did you get any medical imaging done? **Y/N**

Please note: Your appointment time has been reserved for you. As a courtesy to your therapist and fellow patients, we ask that you provide us with 24 hours' notice for cancellations or changes to appointment lengths or times. If we do not receive adequate notice you will be personally charged the **full cost** of your visit (we cannot bill extended medical insurance, ICBC, WorkSafeBC, DVA, or RCMP for missed or late cancelled appointments.)
*Unpaid bills will be subject to an interest rate of 12% per year, compounded monthly.

I authorize the clinic and its associated RMTs 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. In addition, I authorize the clinic and its associated RMTs to communicate with my referring physician 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.

I confirm that the preceding information is correct *to the best of my knowledge and I have disclosed to my therapists all information that could affect the outcome of the massage treatments.* ***I acknowledge the information regarding cancellations, missed, and changed appointments and am aware of my financial responsibility for them****.*

Patient (or Guardian) Signature: _____ Date:_____