OPTIMAL HEALTH MASSAGE THERAPY & WELLNESS LTD.

Tracy Hansen, RMT – Jennifer Trettenero, RMT

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250-727-2790

CONFIDENTIAL PERSONAL HEALTH INFORMATION

Name: _____ **Email:** _____

Address: _____ **Occupation:** _____

_____ **Daily Tasks:** _____

Postal Code: _____ _____

Phone: (Home) _____ _____

(Cell) _____ **Family Doctor:** _____

(Preferred Contact #): _____ Contact Number _____

Care Card #: _____ **How did you hear about our clinic?**

Birth date: (mm/dd/yy) _____ _____

Please evaluate the following aspects of your current state of well being on a scale of 0-5 (0 being none and 5 being maximum)

Fitness Level: 0 1 2 3 4 5

Nutrition: 0 1 2 3 4 5

Health: 0 1 2 3 4 5

Stress: 0 1 2 3 4 5

Energy: 0 1 2 3 4 5

- Have you ever had massage therapy before? Y/N
- Please state all current medications, supplements and vitamins you are taking: _____
- Chief Complaint: _____
- Other Concerns: _____ _____

Health History: P=PAST C=CURRENT (please check all that apply)

P	C		P	C		P	C		P	C	
-	-	Headache	-	-	Chronic cough	-	-	Hepatitis	-	-	High BP
-	-	Migraine	-	-	Short of Breath	-	-	Herpes	-	-	Low BP
-	-	Vision Problems	-	-	Asthma	-	-	TB	-	-	Poor circulation
-	-	Earaches	-	-	Smoking	-	-	HIV	-	-	Heart Disease
-	-	Jaw Pain	-	-	Sinus infection	-	-	Other Infections	-	-	Stroke
-	-	Dizziness	-	-	Bruise easily	-	-	Constipation	-	-	Menstrual issues
-	-	Fibromyalgia	-	-	Sensitive Skin	-	-	Insomnia	-	-	Pregnancy
-	-	CFS	-	-	Plantar warts	-	-	Depression	-	-	Menopause
-	-	Arthritis	-	-	Athlete's foot	-	-	Poor Appetite	-	-	Endometriosis
-	-	Osteoporosis	-	-	Dermatitis	-	-	Diabetes	-	-	PID
-	-	Whiplash	-	-	Allergies	-	-	Kidney problems	-	-	Liver problems

Please fill out back side of form →

Please list all major surgeries, injuries and accidents including the year and the presenting condition:

_____

_____

Have you ever had any type of cancer? If yes, when? Please list treatments received:

_____

_____

Do you have any artificial pins, plates or joints?

_____

What goals or expectations do you have for massage therapy?

_____

Is there any additional information you would like me to know?

_____

_____

ICBC or WCB clients only	Referring Physician:
Claim #:	Symptoms since the accident:
Date of the accident:	Limitations since the accident:
Adjustor's name:	Did you go to the hospital? Y/N Employer:

Fee Schedule (All prices include HST and are subject to change)	**Cancellation Policy**
30 Minutes ----------$50.40 45 Minutes----------$67.20 60 Minutes----------$84.00 75 Minutes----------$100.80 90 Minutes----------$128.80 120 Minutes----------$168.00 Outstanding interest will be calculated at 12% per annum, compounded monthly, not in advance.	Please note that we require **24 HOURS NOTICE** for all cancellations or changes to appointment lengths or times. If we do not receive adequate notice we will apply a charge to your account as follows. 20 minutes = $20 30 minutes = $30 45 minutes = $45 60 minutes = $60 75 minutes = $75 90 minutes = $90 120 minutes = $120 (WCB, ICBC, DVA, & RCMP clients are personally responsible for this fee.)

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

Signed:_____ Date:_____