Optimal Health
Massage Therapy & Wellness Ltd.

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

CONFIDENTIAL PERSONAL HEALTH INFORMATION

Name:_____ Email:_____
(As it appears on your care card) May we contact you by email? Y/N
Address:_____ Occupation:_____
_____ Daily tasks:_____
Phone:(Home)_____ _____
(Cell)_____ Family Doctor:_____
(Work)_____ Birth Date (mm/dd/yy):_____
(*please indicate preferred contact #) PHN/Care Card #:_____

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: _____

Do you have extended health care insurance? Y/N Which carrier?:_____
Please list any supplements or medications you are/have recently taken and what for:
_____
_____

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

-Headache	-Arthritis	-Osteoporosis	-Fibromialgia (FM)
-Migraine	-Plantar Warts	-Sensitive Skin	-Constipation
-Asthma	-Athlete's foot	-Insomnia	-Kidney Problems
-Earaches	-HIV/AIDS	-Dermatitis	-Depression
-Jaw pain	-Tuberculosis (TB)	-Vision problems	-Poor appetite
-Dizziness	-Sinus infection	-Poor Circulation	-High/Low Blood Pressure
-Whiplash	-Bruise easily	-Diabetes	-Shortness of breath
-Smoking	-Hepatitis	-Stroke	-Chronic fatigue (CFS)
-PID	-Liver problems	-Pregnancy (#__)	-Endometriosis
-Herpes	-Heart Disease	-Chronic Cough	-Menstrual Issues
-Menopause	-Mental illness	-Eczema	-Mental/Emotional Stress
-Epilepsy	-Varicose Veins	-Hearing problems	-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?_____
_____
Do you have any habits (Drugs/Alcohol/Other)?:_____
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:_____ Adjustors 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. In courtesy of 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 charged the **full cost** of your visit.
*ICBC, WorksafeBC, DVA, and RCMP patients will be personally responsible for the full cost of the missed or late-cancelled appointment.
*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 also acknowledge the information regarding **cancellations, missed, and changed appointments** and am aware of my financial responsibility for them.*

Patient (or Guardian) Signature:_____ Date:_____