Serene Massage Therapy Medical History Form

#201 – 636 W. Broadway
Vancouver, BC V5Z 1G2
604-879-5995

NAME _____ *DATE* _____

Preferred pronoun _____

ADDRESS _____ *PHONE (Cell)*_____

_____ *(Other)*_____

_____ *E MAIL* _____

HOW DID YOU HEAR ABOUT US? _____ _____

OCCUPATION _____ *BIRTHDATE*_____

Main Complaint :

When /how did this condition begin?

What aggravates or relieves it?

Do you feel adequately hydrated? *Y / N*

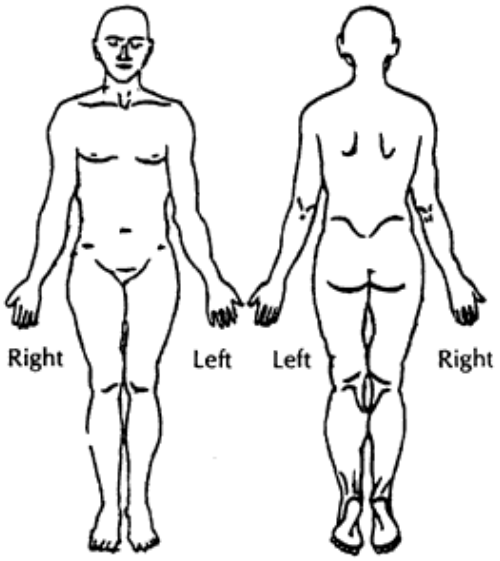
Have you ever experienced any of the following? Please explain

☐ MVA: ☐ Illness: ☐ Surgery: ☐ Injury:

Medications? pain relievers/anti-inflammatory, muscle relaxants/other; please describe

Allergies?

Indicate Areas of Concern



PLEASE CHECK OFF ALL OF THE FOLLOWING THAT APPLY TO YOU (Past or Current)

☐ ***Spinal Disc Problems***	☐ ***Hepatitis***	☐ ***Stroke***
☐ ***Joint Dislocation***	☐ ***HIV Positive***	☐ ***Diabetes***
☐ ***Heart Condition/Pace maker***	☐ ***Cancer***	☐ ***Kidney Disease***
☐ ***Muscle Strain/Ligament Sprain***	☐ ***Fractures***	☐ ***Headaches/Migraines***
☐ ***Whiplash***	☐ ***Stress***	☐ ***Epilepsy/Seizure Disorders***
☐ ***Asthma/Bronchitis/Emphysema***	☐ ***Depression/Anxiety/Insomnia***	☐ ***Chronic Sinusitis***
☐ ***Low/High Blood pressure***	☐ ***Skin Condition***	☐ ***Irritable Bowel/Colitis***
☐ ***Dizziness/Fainting***	☐ ***Arthritis; Type***	☐ ***Digestive Condition***
☐ ***Vertigo/Ringing in Ear***	☐ ***Fatigue/Low energy***	☐ ***IUD/Implants/Transplant***
☐ ***Osteoporosis***	☐ ***Rods/Pins/Plates/Shunts***	☐ ***Other:***

Please Turn Over

Do you receive care from other practitioners? Please list names of practitioners if applicable.

☐	***Family Physician***	_____
☐	***Naturopath***	_____
☐	***Chiropractor***	_____
☐	***Acupuncturist***	_____
☐	***Fitness Trainer***	_____
☐	***Physiotherapist***	_____
☐	***Other***	_____

Do you have an active ICBC claim? Y / N

Lawyer: _____

_____***24 hours Cancellation Policy:*** *My initials confirm that I understand and agree to the 24 hours cancellation policy. Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.*

_____***Collection of Personal and Medical Information:*** *My initials confirm that 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 it's associated RMTs to communicate with my referring MD 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, or where required by law.*

_____***Sharing of My Patient Record:*** *My initials confirm that I request and authorize my RMT to provide to the Clinic, and to other health care practitioners who provide me with treatment, copies of any patient record created by my RMT. I understand this will enable the Clinic to maintain a complete patient record on my behalf. I understand that I may revoke this permission in writing at any time in the future.*

SIGNATURE _____ ***DATE***_____