CONFIDENTIAL MEDICAL CASE HISTORY
Esquimalt Massage Therapy Clinic Inc.

Name: _____ Date: _____

Occupation: _____ Email: _____

Height: _____ Weight: _____ Birthdate: _____ Gender: _____

Care Card # : _____

Address: _____ Postal Code: _____

Phone #: (Home) _____ (Work) _____ (Cell) _____

Medical Doctor: _____ Doc. Phone #: _____

May the clinic contact your medical doctor? Y or N

How did you hear about our clinic? _____

**** Please initial the boxes on the left to indicate that you understand and will abide by these policies.**

☐ Initials

Fee Policy: Your appointment time is reserved for you. In consideration of your fellow patients and your therapist please allow a minimum of 24 HOURS NOTICE to change or cancel your appointment. **If 24 hours notice is not given, you will be charged the full price of your appointment.**

☐ Initials

The information provided in this Case History Form is true to the best of my knowledge. If there are any changes to my medical history, I understand that it is my responsibility to inform the clinic.

Please indicate if any of the following apply to you by marking **P** = Past or **C**=Current. Leave blank anything that does NOT apply to you.

____ Headache	____ Muscle Spasm	____ Ulcers	____ Diabetes
____ Migraines	____ Muscle tension	____ Pregnancy	____ HIV/AIDS
____ Dizziness	____ Muscle Strain	____ Menstrual Difficulty	____ Cancer
____ Fainting	____ Ligament Sprain	____ Heart Attack/Stroke	____ Resp. Problems
____ Nausea	____ Fracture/Dislocation	____ Athletes Foot/Warts	____ Hepatitis
____ Anxiety	____ Epilepsy/Seizures	____ Varicose Veins	____ GI Problems
____ Low Bl Pressure	____ Hemophilia	____ Bruise Easily	____ Kidney/Liver Cond.
____ High Bl Pressure	____ Spinal Injury	____ Scoliosis	____ Skin Condition/Rash
____ Herpes/Shingles	____ Head Injury	____ Arthritis	____ Contagious Cond.

Please list any other conditions that you have had or are experiencing which are not listed above: _____

_____

Please Turn Over

Any past surgeries? If so, please briefly describe and indicate date: _____

_____

Past Motor Vehicle Accident? If so, please indicate how many and date of occurrence: _____

_____

Please list any medications you are presently taking: _____

_____

Please list any allergies: _____

Please describe the condition or reason you are seeking treatment today:_____

_____

Have you seen other health care professionals for this condition or reason? Y or N

If yes, by whom? Chiro _____ RMT_____ Physio _____ Doctor_____ Other _____

Have you previously received massage therapy treatments before? Y or N

If yes, when was your last massage? _____

Consent and Release Policy: Your patient file is the property of the Esquimalt Massage Therapy Clinic Inc. In the event you require copies for another health care professional a copying fee will apply.

Please note the Esquimalt Massage Therapy Clinic DOES NOT treat patients on WorkSafeBC claims. Please let your therapist know if you are on a WorkSafeBC claim or are about to go on one.

By my signature below, I acknowledge the above **Clinic Policies** and authorize the collection, use and disclosure of personal information, as defined in the Personal Information and Protection Act (PIPA), required for treatment and/or any related administrative purpose. I understand that all my personal information is confidential and must be treated in accordance with PIPA.

If your insurer requires information about your treatment schedule including treatment dates, amounts paid and lengths of treatment, may the clinic give out this information? **YES or NO (please circle one)**

_____ _____

Signature Date