**DOMINELLI MASSAGE THERAPY & WELLNESS**

# CONFIDENTIAL PATIENT HISTORY FORM

Name _____ Birthdate _____

Address _____
_____
Postal Code _____

Family Doctor _____
Phone _____
Referring Professional _____
Phone _____

Phone (Home) _____
(Cell/pager) _____
(Work) _____

Care Card # _____
Extended Medical Insurer _____
ICBC or WCB? No Yes Claim# _____
If active claim, please inform RMT as you will need to fill out the related Claim Form)

E-mail _____
Occupation _____

How did you hear of this clinic?
□ Friend/Relative □ Referred by Doctor/Chiropractor □ Yellow Pages □ Newspaper
□ Walking by □ Referred by Physio/Trainer □ Other (please specify)_____

Name _____

Would you like to be on our contact list for future promotions / events / future newsletters?___Yes___No

Please indicate if you believe any of the following apply to you (P = past) (C = current)

- Heart Attack
- High / Low Blood Pressure
- Stroke or Aneurysm
- Pace Maker
- Other heart condition
- Varicose Veins
- Bruise easily
- Other Circulatory condition.
- Diabetes
- Kidney Disease
- Other Urinary condition.
- Hemophilia
- Headaches / Migraines
- Dizziness / Fainting
- Nausea
- Spinal injury
- Head injury
- Epilepsy / other seizures
- Other Neurological condition.
- Asthma
- Chronic Sinusitis
- Other Respiratory condition
- Irritable Bowel / Colitis
- Digestive condition
- Skin condition
- Joint Dislocation
- Bone Fracture
- Arthritis
- Osteoporosis
- Rods / pins / plates /shunts
- Implants _____
- Transplant_____
- Corrective Lenses/Contacts.
- Cancer
- Hepatitis
- HIV
- Other Contagious condition _____
- Pregnancy

Have you ever been hospitalized, had any major accidents, illnesses, or surgeries? ____Yes ____No
Please comment _____

Continued over…

Since January 1st have you visited any of the following? (Please check all that apply)
□ Chiropractor □ Massage Therapist □ Naturepath □ Physiotherapist □ Podiatrist

How many visits have you had since January 1st? _____

Please list any Medications you presently take:

_____

_____

Known Allergies:

_____

_____

List any Activities, Sports, Hobbies
(ie. Jogging, Hockey, Crafts, Computer, etc)

_____

_____

_____

List any NON-prescription vitamins, minerals or other supplements you are taking.

_____

_____

_____

Please CIRCLE the answer closest to how you PRESENTLY feel: (1=poor 5=excellent)

| | | | | | |
|---|---|---|---|---|---|
| Quality of Sleep | 1 | 2 | 3 | 4 | 5 |
| Energy Level | 1 | 2 | 3 | 4 | 5 |
| Eating Habits | 1 | 2 | 3 | 4 | 5 |
| Stress Level | 1 | 2 | 3 | 4 | 5 |
| Exercise Habits | 1 | 2 | 3 | 4 | 5 |

Hours of sleep per night (approx) _____

Number of meals you regularly eat per day _____

Number of times you exercise per week _____

| | | | |
|---|---|---|---|
| Smoker | Yes | No | Occasional |
| Alcohol | Yes | No | Occasional |

## Current Condition

Please describe your current condition & symptoms

_____

_____

_____

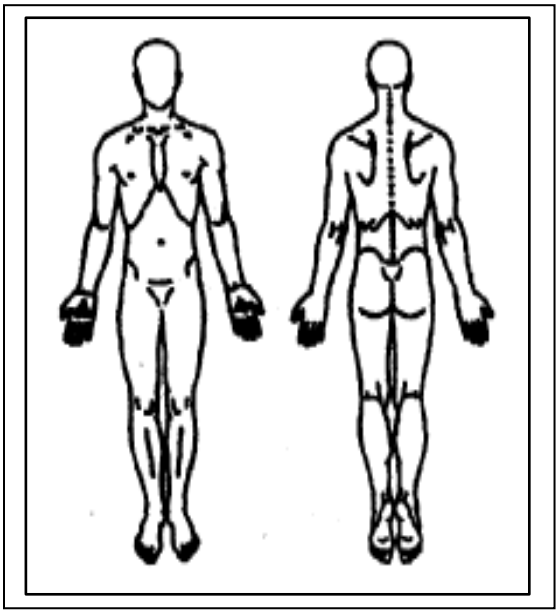
How long have you had this condition? _____

How did it start? _____

_____

The problem / condition is: (Please circle)
○ improving ○ getting worse ○ stays the same
○ constant ○ worse in morning
○ comes and goes ○ worse in evening

Indicate areas involved



**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 of cancellation, or a cancellation fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

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 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.

**Signature**: _____ **Date**: _____

# Cancellation Policy; Third Party Billing

**To avoid a cancellation fee we require a minimum of 24 hours notice when cancelling or rescheduling an appointment.** Your appointment time has been reserved for you, in courtesy of your practitioner and fellow patients, we ask that you please call if you are unable to hold your scheduled appointment. If less than 24 hours notice is provided we will make every effort to fill the appointment. In the event we are unable to fill the appointment you will be presented with a bill for the full amount of treatment at your practitioners' discretion. Please be aware that a receipt will be issued for the cancellation fee, however this cancellation fee is not reimbursable through extended benefits provided by third party insurers.

It is the responsibility of the patient to determine if their supplemental or extended health care insurance may provide coverage for massage therapy treatment. Payment for all treatments whether private or insured is ultimately the responsibility of the patient. A receipt will be issued for each payment.

Thank you for your cooperation.

_____ _____

Patient Signature Date

_____

Patient Name

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