Confidential Health History

Interactive Flex Massage Therapy
Marlies Russell, RMT
6996 West Saanich Road
Brentwood Bay, BC V8M 1G5

Name: _____Birth Date: _____

Best # to reach you: Home/Work/Cell _____ Email: _____

Address: _____ Postal Code: _____

Occupation: _____Referring Dr. _____

How did you hear about the clinic? _____ May we contact you via email? Yes No

Are you taking any medications? Painkillers Blood Pressure Sleep Muscle Relaxants Anti-coagulants

Depression Non-prescription Vitamins/Minerals Other _____

List favourite sports, activities, hobbies (i.e., jogging, hockey, crafts, computer, etc): _____

_____

Serious injuries, surgeries or accidents with dates: _____

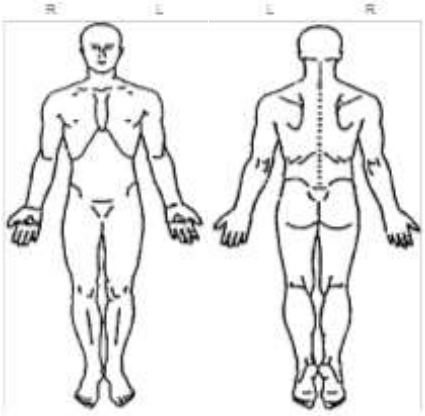
_____

Seeking other therapies? Chiropractor Physiotherapist Naturopath Other: _____

Please **CIRCLE** how you presently feel: 1=Poor 5=Excellent

Quality of sleep	1	2	3	4	5	Hours of sleep / night: _____
Energy level	1	2	3	4	5	
Eating habits	1	2	3	4	5	# of meals / day: _____
Stress level	1	2	3	4	5	
Exercise habits	1	2	3	4	5	# of days / week you exercise: _____

Please show on the diagram the area's that you feel pain / discomfort



Please describe your current condition & symptoms: _____

_____

_____

How long have you had this condition? _____

What aggravates it? _____

What relieves it? _____

ICBC or WCB claim? Claim #_____ Date of accident: _____

Adjuster's Name & Phone #: _____

Lawyer's Name & Phone #: _____

Over ⇨

Please indicate any of the following conditions that apply to you:

Allergies
Aneurysm
Artificial implants
Arthritis (type) _____
Asthma
Blood clots
Blood pressure: Low High
Blurred Vision
Bronchitis
Bruise Easily
Cancer (type) _____
Chest pain
Connective tissue disorder
Contagious diseases
Depression / Anxiety
Diabetes
Diarrhea / Constipation
Digestive disorders
Disk problems
Ear problems
Eczema
Edema
Emphysema
Epilepsy
Fainting / Dizziness
Fatigue / Low energy
Fractures (type) _____
Headache X/week _____
Heart condition
Hemophilia
Hepatitis
HIV positive
Hyper / Hypo Thyroid
Insomnia
Jaw pain
Joint dislocation
Kidney Disease
Lupus
Menstrual Difficulties
Metal plates / pins
Multiple Sclerosis
Nail disorders
Neuralgia
Neurological conditions
Pacemaker
Plastic Surgery: _____
Pregnant (present)
Psoriasis
Scleroderma
Shortness of breath
Sinus condition
Skin condition
Skin conditions
Stroke (CVA)
Varicose Veins

Your time is valuable and so is mine. Please understand that your appointment time is reserved for you and acknowledge that you will be charged the **full rate of your appointment time** if you do not give 24 hours notice of a change or cancellation of appointment.

By my signature below, I 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 of my personal information is confidential and must be kept in accordance with PIPA.

I understand that by attending my appointment and signing this health history form that I am giving my consent for treatment, however I am aware that my consent can be withdrawn at any time before or during treatment.

Signature: _____ Date: _____