CONFIDENTIAL PATIENT HISTORY FORM

HEALTH CYCLE MASSAGE
Phone: 778.866.9558
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Name _____ **Birthdate** _____
(month / day / year)

Address _____ **Family Doctor** _____

_____ Phone _____

Postal Code _____ **Email** _____

Phone (home) _____

(cell/pager) _____

(work) _____

Email _____

Occupation _____

In case of emergency

Phone _____

Email _____

How did you hear about our clinic? _____

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

_ 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

_ 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
_____

Please list any Medications you presently take:

_____

_____

Known Allergies (including medications, foods, seasonal, oils and lotions, etc.)

_____

Do you have any family history of medical conditions? ❑ **Yes** ❑ **No**

Please list: _____

Have you ever been hospitalized, had any major accidents, illnesses, or surgeries? ❑ **Yes** ❑ **No**

Please comment: _____

_____

Other therapy / treatment: (past or present, does not have to be related to this visit)

	Date of last visit	Location
❑ Massage Therapy		
❑ Chiropractor	"	"
❑ Physiotherapy	"	"
❑ Naturopath	"	"
❑ Acupuncture	"	"
❑ Other _____	"	"

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: _____

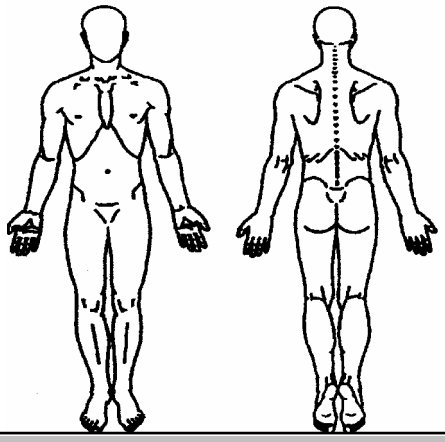
How long have you had this condition? _____

How did it start? _____

What aggravates it? _____

What relieves it? _____

Please indicate on the diagram the nature of your symptoms, using the symbols indicated:



Aching	○ ○
Stabbing	X X X
Shooting	→ →
Burning	# # #
Numbness or Tingling	≈ ≈

Your appointment has been reserved for you. In courtesy of HCM and fellow clients, we that you provide us with 4 hours notice of cancellation, or a fee will be charged. Payment for all treatments is the ultimately the responsibility of the client.
I agree that I have read and understand the following:
I understand that massage is not a replacement for medical care and that no medical diagnosis will be made. Any illicit or sexually suggestive comments or actions made by me will result in immediate termination of the session and I am responsible for full payment.
E-mail Policy: HCM will use your e-mail for appointment reminders, promotions and news from Health Cycle Massage. Your privacy is important to me. HCM will not sell, rent or give your name or address to anyone.

Signature: **Date:**