

**BACK ON TRACK MASSAGE THERAPY
CONFIDENTIAL CASE HISTORY**

Name: _____ Date of Birth(m/d/y): _____

Address: _____ Postal Code: _____

Email: _____ Home Phone: _____

Occupation: _____ Work Phone: _____

Physician's Name: _____ Cell Phone: _____

How did you hear about this clinic? _____

Have you had, or are you having treatment from any of the following?

	<u>Current</u>	<u>Previous</u>	<u>Date of last visit</u>
Massage Therapy	_____	_____	_____
Physiotherapy	_____	_____	_____
Chiropractor	_____	_____	_____
Acupuncture	_____	_____	_____
Other:	_____	_____	_____

Your reason(s) for seeking treatment: _____

How long has it been affecting you? _____

Please describe the nature of your pain: ___ sharp shooting pain ___ dull ache ___ throbbing

Is the pain constant or intermittent? _____

What aggravates the problem? _____

What relieves the problem? _____

On a scale of 1 – 10 (1 being lowest, 10 highest), please rate your pain at this moment. _____

Please list any major surgeries, injuries, and/or accidents: _____

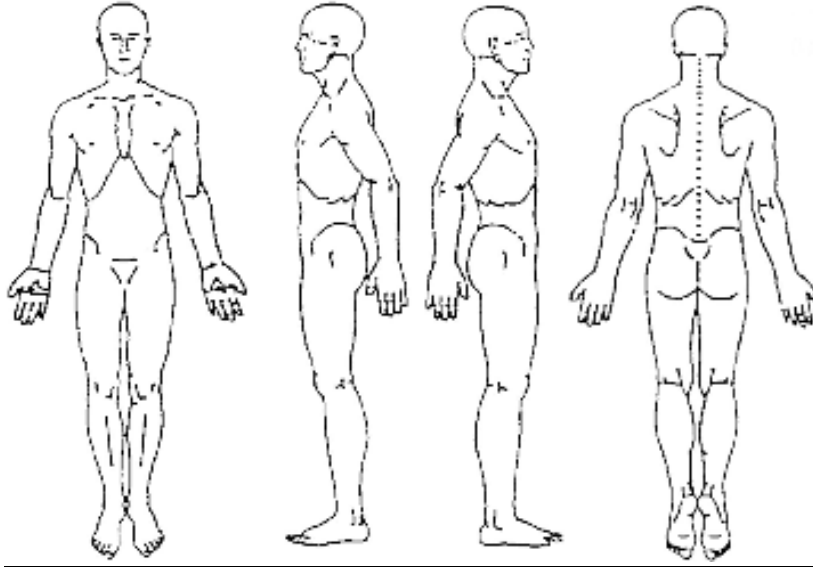
Please list any medications you are currently taking (including non-prescription):

Please list any allergies or sensitivities: _____

PLEASE INDICATE IF ANY OF THE FOLLOWING APPLY TO YOU:

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Other Urinary Condition | <input type="checkbox"/> Chronic Sinusitis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Dizziness / Fainting | <input type="checkbox"/> Other Respiratory Condition |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Nausea | <input type="checkbox"/> IBS or Colitis |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Other Digestive Condition |
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Hepatitis _____ |
| <input type="checkbox"/> Pins / Plates | <input type="checkbox"/> Stenosis | <input type="checkbox"/> HIV /AIDS |
| <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headaches / Migraines → How often? _____ | |
| (If yes) Insulin? Y ___ or N ___ | Other Condition(s): _____ | |

Please Shade Affected Areas:



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PHN: _____ UNIT CODE: _____

Referring MD: _____ Billing Number: _____

Phone: _____ ICBC _____ RCMP _____ DVA _____ WCB _____

Do you smoke? Y ___ or N ___ If yes, how much? _____

Do you drink alcohol? Y ___ or N ___ If yes, how much? _____

Approximately how many hours of sleep do you get each night? _____

Approximately how many glasses of water do you drink each day? _____

Number of meals you regularly eat per day _____

Do you exercise regularly? Y ___ or N ___ If yes, how often? _____

Please list any hobbies, sports or activities you engage in: _____

Please circle the answer closest to how you presently feel:

(1 = poor/low, 5 = excellent/high)

Quality of Sleep 1 2 3 4 5 Energy Level 1 2 3 4 5

Eating Habits 1 2 3 4 5 Exercise Habits 1 2 3 4 5

Stress Level 1 2 3 4 5 Overall Health 1 2 3 4 5

CANCELLATION POLICY

Your appointment time has been reserved just for you. In consideration of your therapist and other patients, **please provide at least 24 hours notice** if you need to change or cancel your appointment. Barring an emergency (ie: illness, accident), **the full fee will be charged for any missed appointments or late cancellations.** Payment for 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 information numbers / email addresses listed 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.

By signing below, you are acknowledging that you have read, and understand the cancellation policy as outlined above. You are also acknowledging that you have given informed consent to receive massage therapy.

Signature: _____

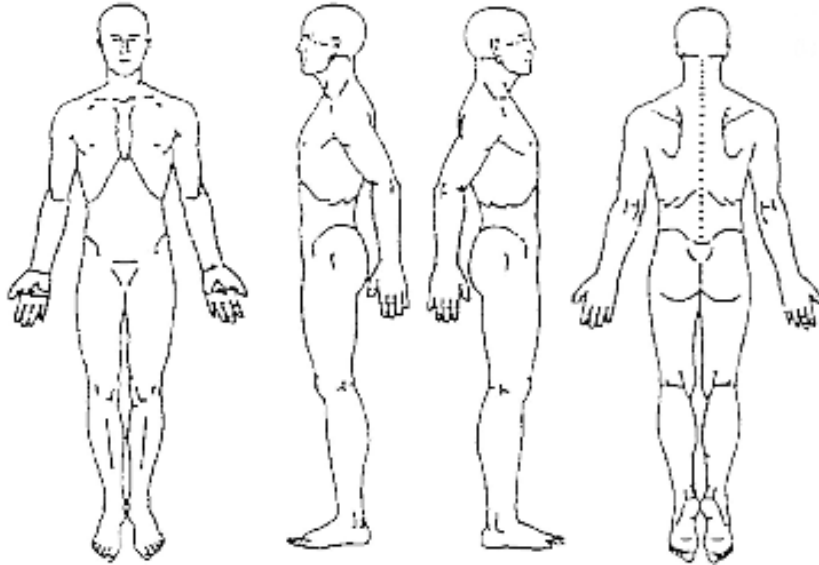
Date (m/d/y): _____

Signature of Parent / Guardian if patient is under 18: _____

FOR OFFICE USE ONLY

Initial Treatment Form

Postural Scan



ROM Assessment:

Area: _____ Motion: _____

Restricted? _____ % Pain? Y ___ or N ___

Nature of Pain: _____

Special Tests:

_____ + or -

_____ + or -

_____ + or -

Therapist: _____ Tx Length: _____

Ins: _____ Tx #: _____

Tx Date: _____ AREA(S) TREATED:

MODALITIES USED:

___ AT ___ MET ___ SWED

___ MFR ___ XFF ___ Jt Mobs

___ TPR ___ CST ___ Mm Str

Subj: _____

S/S: _____

Remex/Notes: _____

Thumper: ___ Biofreeze: ___ Thermophore: ___