BROADWAY WELLNESS
2501 Spruce St. Vancouver, BC
604.732.5222
broadwaymassageandtherapy.com

CONFIDENTIAL PATIENT HISTORY FORM

Today's Date: _____

Name_____ **Birthdate**_____
Address_____ **Phone 1**_____
_____ **Phone 2**_____
Occupation_____
Email_____ **Referring Provider**_____

MEDICAL HISTORY

Please list any medications you presently take_____
_____
Please list any known allergies _____
_____
Please list all major accidents and broken bones to date_____
_____
_____
_____
Please list all surgeries to date_____
_____
_____
_____
Please list all major illnesses to date_____
_____
_____
_____

Are you pregnant? Yes/No If yes, how far along?_____

Do you have any foreign bodies, ie: IUD, pacemaker, metal screws or plates, wire mesh (hernia repair) – please circle or list other(s) here _____

Circle any other therapy / treatment you are presently receiving:
Massage Therapy / Chiropractor / Physiotherapy / Naturopath / Acupuncture / other_____

Please comment on level of fitness and forms of activity_____
_____

CURRENT CONDITION

Please describe your current condition and symptoms_____
_____
_____
How long have you had this condition?_____

How did it start?_____

_____

Please check (√) conditions you are experiencing presently and (circle) conditions you have experienced in the past.

SKIN: □ Rashes / bruise easily □ Other_____

MUSCULAR: □ Weakness or loss of strength □ Osteoporosis/osteopenia □ Rheumatoid arthritis □ Osteoarthritis
□ Tendonitis □ Sprain/strain □ Other_____

RESPIRATORY: □ Asthma □ Bronchitis □ Difficulty breathing □ Emphysema
□ Smoking □ Other_____

CARDIOVASCULAR: □ High/low blood pressure □ Heart attack □ Stroke □ Poor circulation
□ Other_____

HEAD AND NECK: □ Visual impairment □ Hearing impairment □ Speech impairment □ Headaches/Migraines
□ Jaw pain (TMJD) □ Sinus problems □ Other_____

GI TRACT: □ Constipation/Diarrhea □ Gas □ Painful elimination □ Other_____

OTHER: □ Diabetes □ Cancer □ Fainting □ Fever □ Insomnia □ Numbness/tingling □ Stress
□ Depression □ Anxiety □ Other: please comment_____

CANCELLATION POLICY AND CONSENT FOR TREATMENT

The therapists at this clinic run their own practices, and receive their sole source of income from the treatments they provide for you. Your appointment time has been reserved especially for you. In courtesy to your therapist, and fellow patients, we require that you provide us with **24 hours notice** of any cancellation, or change of appointment time. In the absence of 24 hours notice, you will be charged the full cost of your treatment, unless we are able to fill your appointment with another client, in which case, you will not be charged. Also, therapists at this clinic are opted out. This means payment for all treatments, whether private or insured, is ultimately the responsibility of the patient.

"I authorize Broadway Wellness 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. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission. I understand and accept the conditions listed above outlining the Broadway Wellness cancellation policy and I give full consent for treatment".

Signature:_____ **Date:**_____

Additional notes (therapist use only):