610 -2525 Willow St. Vancouver, BC
604.732.5222
broadwaymassageandtherapy.com

CONFIDENTIAL PATIENT HISTORY FORM
REGISTERED MASSAGE THERAPY

Name_______________________________________ **Birthdate**_______________________________________
Address____________________________________ **Phone 1**____
____ **Phone 2**____
Occupation_________________________________ **Gender**____
Email______________________________________ **Referring Provider**_______________________________
Doctor_____________________________________**Phone**____
Permission to consult your doctor regarding your condition? No__ Yes__
Do you currently have an active ICBC or WCB claim? No__ Yes__, claim #____________________________

MEDICAL HISTORY

Reason for treatment:____
____

Date of onset:____

Symptoms:____
____
____

Has the condition occurred before? No__ Yes__

Please list any medications you presently take ____
____

Please list any known allergies____
____

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

History of Trauma: Please list all accidents, injuries, surgeries, broken bones, big falls, blows to the head, major illnesses to date?
____
____
____
____
____
____

Please list all dental work performed (excluding fillings and cleanups):
____
____

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 ____

Please comment on level of fitness and forms of activity ____

____

Are you satisfied with your overall health? Yes__ No __ Comment:____

____

Medical History P= Past C = Current

CHILDHOOD:

Birth Trauma __
Feeding problems __
Colic __
Recurrent ear infections __
Developmental delays __
Hyperactivity/ADD/ADHD __
Learning disabilities __
Eye motor problems __
Hospitalized for any reason __

GASTROINTESTINAL:

Heartburn __
Nausea __
Gas __
Ulcer __

RESPIRATORY:

Shortness of breath __
Bronchitis __
Asthma __
Emphysema __

CARDIOVASCULAR:

Heart condition __
Stroke __
High/Low blood pressure __
Pacemaker etc. __
Arteriosclerosis __
Cardiovascular aneurysm __
Phlebitis or Varicose Veins __

HEAD & SPINE:

Head injury __
Spinal injury __
Headaches __
Migraines __
Jaw pain/clicking/locking __
Fainting / dizziness __
Vision problems __
Ear/hearing problems __
Ringing in ears __
Sinus problems __
Facial pain __
Other neurological __

OTHER:

Arthritis __
Infections __
Susceptible colds.illness __
Insomnia __
Low energy /Fatigue __
Skin conditions __
Pregnancy __
Cancer __
Epilepsy / seizures __
Diabetes __
Hepatitis __
Kidney condition __
Contagious condition __
Stress / anxiety __
Difficulty relaxing __
Depression __
Other: ________________

Is there anything else that your therapist should know?____

____

____

CLINIC POLICIES, CONSENT, DISCLAIMER

Patient Name: ___________________________ DOB: (dd/mm/yy): _______________________

Broadway Wellness (Broadway Massage Therapy Inc) provides space and administrative services to independent healthcare professionals who provide multi-disciplinary, integrative health services, including Registered Massage Therapy.

To provide you with optimal care, the healthcare professionals at Broadway Wellness share a client record keeping system. All professionals and staff comply with the privacy regulations of their professional colleges, as well as by provincial law.

Please initial next to the following to indicate your understanding and consent:

CONFIDENTIALITY AND CONSENT TO TREATMENT:

___ My file is accessible to the RMT's at Broadway Wellness. I authorize my RMT to provide to the Clinic and to other health care practitioners who provide me with treatment, copies of any patient record created by my RMT. I understand this will enable the Clinic to maintain a complete patient record on my behalf. I understand that I may revoke this permission in writing at any time in the future.

___ 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 with my intake form.

___ The contents of this form and my patient records will be kept confidential unless I have expressly or impliedly consented to the release of my information or where there is a legal requirement to provide my information to a third party.

___ I have disclosed my relevant medical history to my RMT, and I will disclose any new condition that may develop after my completion of this form.

___ The information disclosed by me is true and complete to the best of my knowledge.

___ I understand that no guarantee or assurance of results has been made to me regarding my treatments.

PAYMENT AND CANCELLATION POLICIES:

___ You are responsible for the full payment of any fees incurred during your visit to Broadway Wellness at the end of each visit. 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.

DISCLAIMER:

___ Broadway Wellness (Broadway Massage Therapy Inc) does not provide health care services to the public. All such health care services are provided by the independent health care practitioners who operate from the space provided by Broadway Wellness (“Practitioners”, and each a “Practitioner”). Any questions or concerns you have in regard to your health services are discussed with your Practitioner.

Broadway Wellness expressly denies liability associated with the provisioning of health services by any Practitioner to you. By signing this informed consent, you acknowledge and agree that Broadway Wellness is not liable for any claim(s) arising from the relationship between you and any Practitioner.

Signature of Patient*: (* In the case of a person incapable of providing consent, signature of Parent or Guardian, in which case the Name & Relationship of Person Signing: ___________________________________.)

____   ____

Signature   Date: (dd/mm/yy)