Registered Massage Therapists
Doctor of Chiropractic
Licensed Acupuncturist

CONFIDENTIAL PATIENT HISTORY FORM

Name _____

Address _____

_____

Postal Code _____

Phone (home) _____

(cell) _____

(work) _____

Email _____

Occupation _____

Birth date _____

Family Doctor _____

phone _____

Referring Professional _____

phone _____

Care Card # _____

Extended Medical Insurer: _____

ICBC or WCB? **Yes** **No**

Claim # _____

How did you hear about New Leaf Massage and Wellness?

_____

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

- Heart Attack	- Spinal Injury	- Digestive condition	- Cancer
- High/Low Blood Pressure	- Dizziness/Fainting	- Skin condition	_____
- Stroke or Aneurysm	- Nausea	- Joint Dislocation	- Hepatitis
- Pace Maker	- Head Injury	- Bone Fracture	- HIV
- Heart Condition	- Epilepsy / other seizures	- Arthritis	- other contagious
- Varicose Veins	- other Neurological conditions	- Osteoporosis	condition
- Bruise easily	- Asthma	- Rods / Pins / Plates / Shunts	_____
- Kidney Disease	- Chronic Sinusitis	- Implants _____	
- Urinary condition	- Respiratory condition	- Transplants _____	
- Headaches/Migraines	- Irritable Bowel / Colitis	- Corrective Lenses / Contacts	

Please list any Medications/ Vitamins/Minerals you presently take:

_____

_____

Continued over ...

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

_____

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

Please comment: _____

Please indicate if you have received any of the following this year:

Massage Therapy ___ Chiropractic ___ Acupuncture___ Physiotherapy ___

List any Activities, Sports, Hobbies (i.e Jogging, Hockey, Crafts, Computer, ect):

_____ _____ _____ _____

Please CIRCLE the answer closest to how you PRESENTLY feel: (1 = poor, 5 = excellent)

Quality of sleep	1	2	3	4	5	Hours of sleep per night (approx.)			____
Energy Level	1	2	3	4	5	Number of meals you regularly eat per day			____
Eating Habits	1	2	3	4	5	Number of times you exercise per week			____
Stress Level	1	2	3	4	5	Smoker	Yes	No	Occasional
Exercise Habits	1	2	3	4	5	Alcohol	Yes	No	Occasional

Current Condition

Please describe your current condition & Symptoms:

_____

_____

How long have you had this condition: _____

How did it start: _____

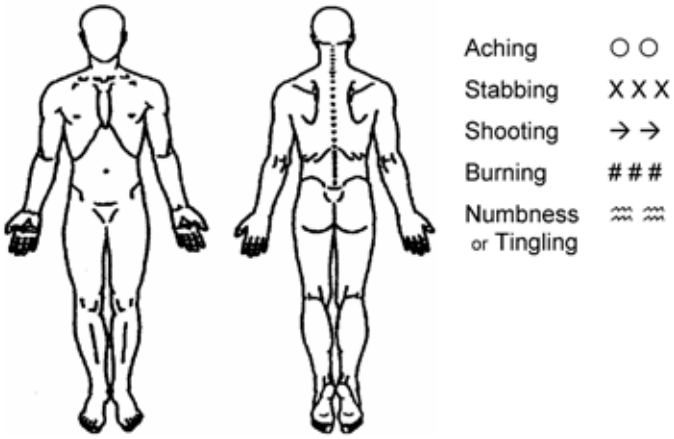
What aggravates it: _____

_____

What relieves it: _____

_____

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



Please Note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for all treatments, whether private or insured, is ultimately the responsibility of the patients. Late cancelation fees will be 50% of scheduled appointment time. Under one hour notice OR no show will be charge full appointment fee.

I authorize the clinic and its associated health care professionals 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. In addition, I authorize the clinic and its associated health care professionals to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my person and medical information is confidential and will only be disclosed to third parties with my permission

Signature: _____ **Date:** _____