Mission Massage Therapy Centre
#290-1855 Kirschner Road, Kelowna, BC, V1Y 4N7
Phone/Fax: (250) 861-8900

Date: _____

Confidential Health History Form

Name:_____ Birthdate (m/d/y):_____

Address:_____ City:_____ Postal Code:_____

Phone #: (H) _____ (C) _____ (W) _____

Occupation:_____ CareCard #:_____ Extended Medical Provider:_____

Family Doctor:_____ Referring Professional:_____

How did you hear about our clinic?:_____

ICBC or WCB Claim? Yes/No Claim #:_____ Date of Accident:_____
(If active claim, please inform RMT as you will need to fill out the related Claim Form)

Please indicate any of the following conditions that apply to you: (P=past, X=current, F=family history)

__ Heart Attack	__ Headaches/Migraines	__ Asthma
__ High/Low Blood Pressure	__Dizziness/Fainting	__ Other Respiratory Condition
__ Stroke or Aneurysm	__ Nausea	__ Arthritis
__ Pace Maker	__ Spinal Injury	__ Osteoporosis
__ Other Heart Condition	__ Head Injury	__ Rods/Pins/Plates/Shunts
__ Varicose Veins	__ Epilepsy/Other Seizures	__Cancer
__ Bruise Easily	__ Other Neurological Condition	__Hepatitis
__ Other Circulatory Conditions	__ Fibromyalgia	__ HIV
__ Diabetes	__ Myofascial Pain Syndrome	__ Other Contagious Condition
__ Kidney Disease	__ Digestive Condition	__ Allergies/Sensitivities

List all medications you presently take: _____

_____

Surgeries, injuries, or accidents you have had: _____

_____

Are you also seeing (circle): Chiropractor Physiotherapist Naturopath Other: _____

If so, how often?: _____

Current Condition:

Major area of complaint: _____

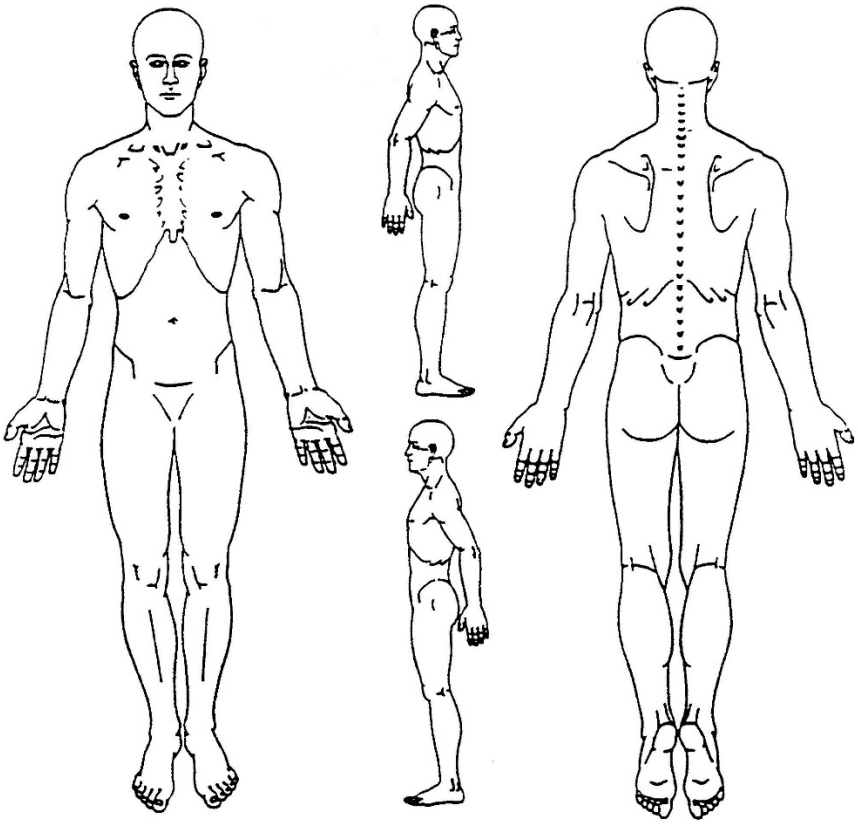
How long have you had this condition?: _____

How did it start?: _____

What aggravates it?: _____

What relieves it?: _____

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



000 Aching

XXX Stabbing

→→ Shooting

Burning

^^^ Numbness/Tingling

Please Note: Your appointment time has been reserved for you. In courtesy of your therapist and fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for treatment, whether private or insured, is ultimately the responsibility of the patient.
I authorize the clinic and its associated RMTs to collect any 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 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.

Signature: _____ Date: _____

(For Office Use)

Date	Treatment	Tx #	Payment	Owing

Date	Treatment	Tx #	Payment	Owing