NICOLA VALLEY
MASSAGE THEREAPY CLINIC
Confidential Case History Form

Name_____________________________________Gender M____ F____ Date _________________

Care Card Number ________________________________ Date of Birth _____________________

Address ____ Postal Code ______________________

Phone home __________________ work ____________________ Cell ________________________

Email _____________________________________ Cellular Carrier _________________________

WHO can we thank for referring you to us? ____

Reason for treatment: ____

Describe the onset ___ Sudden ___ Burning ___ Dull ___ Aching ___ Shooting ___ Other

What aggravates the pain _______________________What relieves the pain ___________________

Does the pain affect your daily activities? __ Y __ N If yes then how __________________________

Is the pain worse in the AM or PM? (circle) DATE OF INJURY_____________________________

Other symptoms? __ grinding __ popping __ Numbness __ Weakness __ Vomiting __ Other

Has this condition occurred before? ______ Was it resolved? _______

Are you taking any medications? _____________________________________ or please provide a list.

Are you seeing a MD, RMT, Chiropractor, Physiotherapist, Other. (Circle applicable)

List any RELEVENT surgeries, accidents, or illnesses. ______________________________________

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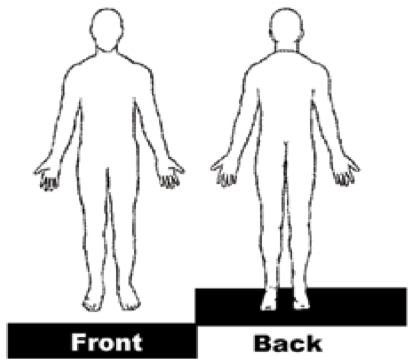
What is your occupation? ____

Does it involve extended periods of sitting ___ standing ___ Lifting ___ computer work___ repetitive movement ___.



Please mark the area(s) of pain

Medical History

Have you ever had or currently have:

Heart Condition	__	Skin Condition	__
Stroke	__	Circulatory	__
Infection	__	Kidney Condition	__
Recent Surgery	__	Contagious infection	__
Dislocation	__	Digestive Problems	__
Cancer	__	Arthritis	__
Fractures	__	Insomnia	__
Head Injury	__	Fainting	__
Headaches	__	Spinal Injury	__
Seizures	__	Sprain/Strain	__
Jaw Pain	__	Pregnancy	__
Diabetes	__	Respiratory Condition	__
Allergies	__	High/Low Blood Pressure	__
Limb/Head Implants	__	Steel Pins	__

CANCELLATION POLICY

Please call if you are unable to attend your appointment. **We require 24 hours notice of cancellation.** If you do not show up for your appointment, **you will be charged the FULL AMOUNT of your missed visit.** Appointments that are cancelled within 12 hours of your appointment time will be charged to you if we cannot fill your spot.

Initials _________

PATIENT CONSENT

Registered Massage Therapist Tim Kroeker makes every effort to ensure that your treatment is safe and effective. Massage therapy involves manipulation of the soft tissues and joints of the body, and the approach to treatment may vary depending upon the patient's conditions(s). At any time before or during the massage therapy treatment, you have the right to ask that the treatment or portion of the treatment be discontinued or enquire about the purpose of any technique being used. If at any time you have any questions or concerns related to the treatment, Tim encourages you to communicate with him so that there may be clarification or modification of the treatment.

The case history form will be kept as part of your patient file. All information within your file, including your case history form, will be kept confidential and will not be released without your prior consent. You will be required to pay for treatment fees that may not be covered by your insurance, medical and legal report fees, and missed appointment fees. Please sign below to indicate that you have read and understand the above information and that the information you have provided in the case history form is accurate.

Patient Name (Print):____

Sign (Guardian if under 18) ____