

Please fill out our confidential Patient Health Record completely and accurately.
If you have any questions, please don't hesitate to ask your practitioner.

IS THIS VISIT RELATED TO:

ICBC CLAIM

RCMP

PERSONAL INFORMATION

REASON(S) FOR YOUR APPOINTMENT

Legal Given Name: _____

Surname: _____

Preferred Name: _____

BC Medical #: _____

Birthdate (mm/dd/yyyy): _____ / _____ / _____

Age: _____

Address: _____

City: _____ Prov: _____ Postal: _____

Occupation: _____

Home #: _____ Work #: _____

Mobile #: _____

Email: _____

Emergency Contact: _____

Phone #: _____

Name: _____

Current Medical Practitioner: _____

Phone #: _____

Date of last physical examination? _____

Briefly describe your main concern(s):

Overall, how is your general health?

List of current medications:

Is the purpose of this visit appointment related to?

- Job Injury Auto Accident Fall Injury Sports Injury
 Chronic Discomfort Wellness Care Other

How long have you had this condition? _____

Is your condition getting: **worse** **better** **same**

What seems to make the condition **better**?

What seems to make the condition **worse**?

What have you tried that has **not worked**?

Is it interfering with your:

- Work Sleep Daily Routine Other

Have you seen a:

- Chiropractor Physiotherapist
 Massage Therapist Acupuncturist

Text

Date of last treatment: _____

Were you happy with the results? Yes No

If **NO**, why? _____

Have you seen any other physician or healthcare professional
for this complaint? Yes No

If **YES**, who? _____

Date of last treatment? _____

Were X-rays or any other medical testing performed?
Yes No

**If auto accident, are you claiming under
Insurance Corp. of BC (ICBC)?**

Yes No

Date of Accident: _____

ICBC Claim #: _____

Adjustor's Name: _____

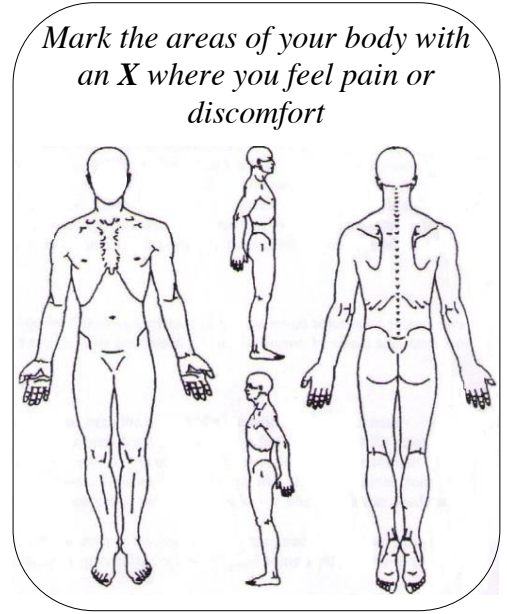
Phone #: _____

PLEASE COMPLETE THE FORM ON THE OTHER SIDE

HEALTH HISTORY

Please indicate conditions presently causing you problems, as well as conditions which were a problem in the past.

Musculoskeletal System	Present	Past	Gastrointestinal System	Present	Past
Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Jaw Problems	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Hunger	<input type="checkbox"/>	<input type="checkbox"/>
Upper Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Elbow/Wrist/Knee Problems	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea/ Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Ankle/Foot Problems	<input type="checkbox"/>	<input type="checkbox"/>	Bloody/Black Stool	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gallbladder trouble	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Weight Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory System	Present	Past	Systemic	Present	Past
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	TB	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Cancer: Stage: _____	<input type="checkbox"/>	<input type="checkbox"/>
			MS	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary	Present	Past	Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Ear, Eyes, Nose, Throat	Present	Past
Persistent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>
Genito-Urinary System	Present	Past	Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>
Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Ear Discharge/ Ear Pain	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Urination	<input type="checkbox"/>	<input type="checkbox"/>	Ear Ringing/ Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Scanty Urination	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat/ Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Discolored Urine	<input type="checkbox"/>	<input type="checkbox"/>	Enlarge Glands	<input type="checkbox"/>	<input type="checkbox"/>
Nervous System	Present	Past	Female	Present	Past
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/ Loss of feeling	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Hormonal Contraceptives	<input type="checkbox"/>	<input type="checkbox"/>
Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual pain	<input type="checkbox"/>	<input type="checkbox"/>
Confusion/ Forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>	Irregular cycle	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Menopausal?	Yes	No
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant?	Yes	No
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Due Date? _____		
Allergies	Present	Past	Male	Present	Past
Seasonal/ Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Pain	<input type="checkbox"/>	<input type="checkbox"/>			
Drug	<input type="checkbox"/>	<input type="checkbox"/>			
Food	<input type="checkbox"/>	<input type="checkbox"/>			
Other: _____					



Orthopedic metal implants?
Yes No
Explain: _____

Recent cortisone injections?
Yes No
Explain: _____

Had any broken bones?
Yes No
Explain: _____

Been struck unconscious?
Yes No
Explain: _____

Any significant accidents or injuries?
Yes No
Explain: _____

Had surgery?
Yes No
Explain: _____

Had any major strains or sprains?
Yes No
Explain: _____

Use orthotics, heel lifts, or insoles?
Yes No
Explain: _____

Scale from 1 (not painful) to 10 (very painful); please indicate your pain level?

The information on this form is true to the best of my memory and I consent to further evaluation as deemed appropriate by the Practitioner. I have agreed to receive email appointment reminders, newsletters, and other correspondence relating to my treatment(s) at e.volve health and wellness.

**24 HOUR CANCELLATION FEE WILL APPLY IF PATIENT DOES NOT CALL TO CANCEL
24 HOURS PRIOR TO APPOINTMENT.**

Patient Initials: _____

Patient Signature: _____ Date: _____

MESSAGE THERAPY INFORMED CONSENT

I, _____, consent to having
_____, RMT, performing Massage Therapy as defined
by the scope of practice for RMTs regulated by the College of Massage Therapists of British
Columbia under the Health Professions Act of Canada.

I understand the treatment and procedure, the risks involved and the possibility of complications. I appreciate there can be no guarantee of assurance as to results and that further treatment may be necessary. I do not expect the Practitioner to be able to anticipate and explain all risks and complications and I wish to rely on the Practitioner to exercise judgment during the course of the procedure which the Practitioner feels at the time, based on the facts known, is in my best interest.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I understand that massage therapy is not a substitute for a medical examination.

I have read the above consent. I have also had an opportunity to ask questions about its content and by signing below, I agree to the above named procedure by the Practitioner. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Signature: _____ Date: _____

If the patient is under the age of 19 years of age

I the parent/guardian of the minor patient understand and consent to the practitioner performing on my child the treatment and procedure described in the above consent.

Signature: _____ Date: _____