



CONFIDENTIAL PATIENT HISTORY
CONSENT TO TREATMENT



Name	_____	Occupation	_____
Address	_____	Birthdate	_____ day/month/year
	_____	Family Doctor	_____
Postal code	_____	Phone	_____
Phone	home _____	Health Care #	_____
	mobile _____	Referring Health Provider	_____
	work _____	ICBC Claim #	_____
Email	_____	WCB Claim #	_____

Please **CHECK** any of the following conditions that apply or have applied to you:

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Joint dislocation |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Dizziness/ Fainting | <input type="checkbox"/> Bone Fracture |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Nausea | <input type="checkbox"/> Sprains |
| <input type="checkbox"/> Stroke or Aneurysm | <input type="checkbox"/> Spinal Injury | <input type="checkbox"/> Arthritis (OA/RA) |
| <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Other Heart condition | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Implants |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> other Seizure disorder | <input type="checkbox"/> Transplants |
| <input type="checkbox"/> other Cardiovascular condition | <input type="checkbox"/> other Neurological conditions | <input type="checkbox"/> Rods/Pins/Plates/Shunts |
| | | |
| <input type="checkbox"/> Diabetes (Type I or Type II) | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> other Urinary condition | <input type="checkbox"/> other Respiratory Condition | <input type="checkbox"/> HIV |
| <input type="checkbox"/> other Kidney Condition | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> other contagious condition |
| | | |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Digestive Conditions | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> Insomnia/Sleep disorders | _____ | <input type="checkbox"/> Corrective Lenses/Contacts |
| <input type="checkbox"/> PTSD | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Other conditions not listed |
| | | _____ |

Please list any **medications** & non-prescription vitamins/supplements you are currently taking _____

Known **Allergies** (e.g., medications, food, seasonal, oils, lotions) _____

Please list any serious accidents, injuries or surgeries with their associated dates _____

Please list any other therapy or treatments you receive/health professionals you see or have seen (e.g., acupuncture, chiropractor, naturopath, physiotherapy) _____

Please list any activities, sports, or hobbies (e.g., jogging, soccer, crafts, computer work) _____

Please circle the answer closest to how you presently feel
(1 = poor 5 = excellent)

Quality of Sleep	1	2	3	4	5	approx. # hours sleep/ night_____
Energy Level	1	2	3	4	5	
Eating Habits	1	2	3	4	5	# of meals/day you eat regularly_____
Stress Level	1	2	3	4	5	
Exercise Habits	1	2	3	4	5	# of times/week you exercise_____

Are you a **smoker**? Yes No Occasional

CURRENT CONDITION

Please describe your current condition and symptoms_____

How long have you had this condition?_____

What triggered it?_____

What aggravates it? _____

What relieves it?_____

When does the condition feel the worst?_____

Does the condition prevent you from sleeping?_____

Declaration:

I hereby declare that the above information is accurate and complete to the best of my knowledge. I have disclosed all relevant past and present health information and agree to inform Kathryn Hodgson, RMT of any changes to the above information. I authorize Kathryn Hodgson to collect my personal information in order to contact me and to leave messages regarding appointments at any of the contact numbers / addresses I have provided above. I also authorize Kathryn Hodgson to collect my medical information as documented above and in future treatment sessions. In addition, I authorize Kathryn Hodgson to communicate with my referring MD or professional as deemed necessary for my beneficial treatment. I fully understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission. Finally, I consent to massage therapy treatment from Kathryn Hodgson.

Signature: _____ Date: _____