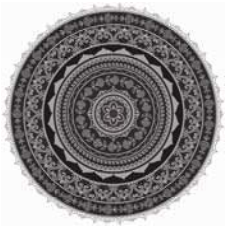

CONFIDENTIAL PATIENT HEALTH HISTORY FORM

Name: Date of Birth (DD/MM/YY):

Address:

City: Province: Postal Code:

Home Phone: Business Phone: Cell Phone:

Email address:

Occupation: Employer:

Doctors name and phone number:

How did you hear about our clinic?

Please list any medications that you are currently taking (*including vitamins, herbs or over the counter drugs such as Aspirin, Tylenol or Advil)*

Have you had massage therapy before? Yes/No Last Visit:

Chiropractic: Yes/No Physiotherapy: Yes/No Other:

Any serious past illness, injuries or surgeries and dates:

List any activities, sports or hobbies:

Is this Motor Vehicle Accident Claim? Yes / No Date of MVA:

Is this a work related injury? Yes/No Date of Injury:

Please indicate if you have had the following done: Xrays/ MRI/ Ultrasound Date:

Please describe your current signs and symptoms: _____

_____

_____

What relieves the condition?_____

What aggravates the condition?_____

Please be advised that your appointment has been reserved for you. In consideration of your therapist and fellow patients, we ask that you provide us with 24 hours notice of cancellation or change, or you will be responsible for the full treatment fee. Payment for all treatments, whether private or insured, is ultimately the responsibility of the patient. I understand that my personal and medical information is confidential and authorize the clinic and its associated RMT's to collect this information and to communicate only with my referring MD. I understand that massage therapy treatments do not guarantee relief of my condition or associated symptoms. I also authorize the treating therapist to address the condition as s/he deems appropriate and to exercise their judgment in regard to my care.

Signature: _____ Date: _____

Soma Massage Therapy
Stephanie Langlais RMT
www.somamassagetherapy.ca