Osborne Bay Massage Therapy Clinic
1530 Morgan Street
Crofton, BC V0R 1R0
250-715-6092

Confidential Client History Form

Date: _____

Name: _____ Birth: _____ Gender: M☐ F☐
Surname/MI/First **MM/DD/YY**

Address: _____ _____ _____ _____
Street, Box # **City** **Prov.** **Postal Code**

_____ _____ _____ _____
Home Ph. **Work Ph.** **Cell Ph.** **E-mail**

_____ _____ _____
Doctor **Phone** **Care Card #**

General Health: Excellent ☐ Good ☐ Fair ☐ Poor ☐ Height: ____ Weight: ____

Occupation: _____

List any Activities, Sports, Hobbies _____

Present medications & the condition used for: _____

_____

Have you ever been involved in any auto accidents? Yes ☐ No ☐

Past or present injuries, surgeries, etc. _____

_____

Are you presently involved in an ICBC litigation/claim? Yes ☐ No ☐ Claim# _____

Please circle areas which are currently causing you discomfort:

Face	Upper back	Arm(s)	Hand(s)	Thigh(s)	Ankles(s)
Neck	Mid back	Elbow(s)	Fingers(s)	Knee(s)	Feet
Shoulder(s)	Lower back	Wrist(s)	Hip(s)	Leg(s)	Toe(s)
Chest	Ribs	Tailbone			

Please check off any of the following that pertain to you:

☐Allergies	☐Dizziness	☐Low BP
☐Aching joints	☐Ear problems	☐Menstrual difficulties
☐Anxiety	☐Emphysema	☐Migraines
☐Asthma	☐Eye problems	☐Muscle pains
☐Bowel/bladder	☐Fainting	☐Osteoarthritis
☐Bronchitis	☐Fatigue	☐Parkinson's
☐Bruise easily	☐Gastrointestinal problems	☐Rheumatoid Arthritis
☐Cancer	☐High BP	☐Skin problems
☐Claustrophobia	☐Hypoglycemia	☐Stroke
☐Cold hands/feet	☐Inflammation	☐Swollen joints
☐Diabetes	☐Jaw problems	☐Tension headaches

Please list any other conditions or symptoms not mentioned above:

_____

_____

☛ See other side

Please check off any of the following therapies you have previously received:

Physiotherapy ☐ Athletic therapy ☐ Massage therapy ☐ Chiropractic therapy ☐

Others: _____

Please CIRCLE the answer closest to how you PRESENTLY feel: (1 = poor, 5 = excellent)

Quality of Sleep	1	2	3	4	5	**Hours of sleep per night** (approx) ____
Energy Level	1	2	3	4	5	
Eating Habits	1	2	3	4	5	**Number of meals you regularly eat/day** ____
Stress Level	1	2	3	4	5	
Exercise Habits	1	2	3	4	5	**Number of times you exercise/week** ____

Smoke	Yes	No	Occasional
Alcohol	Yes	No	Occasional

Payment Policy:
I understand that I am ultimately responsible for the full cost of my appointments, including any event where my insurance company (e.g. ICBC, MSP, DVA, and RCMP) should deny their payment portion to the RMTs.

Cancellation/Missed Appointment Policy: I understand that 24-hours notice is required to cancel or change any appointment. If I miss my appointment, or cancel, or change it, without 24-hours notice, I will be responsible for the full cost of that appointment. *(We thank you for respecting your time, our time, and that of fellow clients.)*

I authorize the clinic and its associated RMTs to collect my 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:**

Office Use

Therapist's comments:

Reason for Initial Treatment: _____

_____

Other notes:

_____

_____

_____

_____

_____

Init._____