WORLDWIDE MASSAGE INC.

CHRISTINE SUTHERLAND RMT #3381 B.C.

Name _____ **Birthdate** _____
(Month/Day/Year)

Address _____ **Family Doctor** _____

Postal Code _____ Phone _____

Phone (home) _____ **Referring Professional** _____

(cellphone) _____ Phone _____

(work) _____

Email _____ **Care Card #** _____

Occupation _____ **Extended Medical Insurer:** _____

ICBC or WCB? **No** **Yes** Claim# _____

How did you hear about (Registered) Massage Therapy? _____

How did you hear about our clinic? _____

Please indicate if you believe any of the following apply to you **(P=Past C=Current)**

Heart Attack	Head Injury	Diabetes
Headaches/Migraines	Rods/Pins/Plates/Shunt	Chronic Sinusitis
Joint Dislocation	Varicose Veins	Cancer_____
High/Low Blood Pressure	Epilepsy/Other Seizures	Kidney Disease
Dizziness/Fainting	Implants _____	Other Respiratory Condition
Bone Fracture	Bruise Easily	Hepatitis
Stroke or Aneurysm	Other Neurological Condition	Other Urinary Condition
Nausea	Transplant _____	HIV
Arthritis	Other Circulatory Condition	Irritable Bowel/Colitis
Pace Maker	Depression	Other Contagious Disease
Spinal Injury	Corrective Lenses/Contacts	Digestive Condition
Osteoporosis	Anxiety	Skin Condition
Other Heart Condition	Asthma	

Please list any medications you presently take:

_____

_____

Known Allergies (including medication, foods, seasonal, oils and lotions, etc.)

_____

Do you have any family history of medical conditions? **Yes** **No**

Please list: _____

Have you ever been hospitalized, had any major accidents, injuries or illnesses? **Yes** **No**

Please comment: _____

_____

Other therapy / treatment: (past or present, does not have to be related to this visit)

☐ Massage Therapy	Date of last visit	_____	Location	_____
☐ Chiropractor	"	_____	"	_____
☐ Physiotherapy	"	_____	"	_____
☐ Naturopath	"	_____	"	_____
☐ Acupuncture	"	_____	"	_____
☐ Other _____	"	_____	"	_____

List any Activities, Sports, Hobbies
(ie. Jogging, Hockey, Crafts, Computer, etc)

_____

_____

_____

List any **NON-prescription vitamins, minerals or other supplements** you are taking:

_____

_____

_____

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

Quality of Sleep	1	2	3	4	5
Energy Level	1	2	3	4	5
Eating Habits	1	2	3	4	5
Stress Level	1	2	3	4	5
Exercise Habits	1	2	3	4	5

Hours of sleep per night (approx.) ____

Number of meals you regularly eat per day ____

Number of times you exercise per week ____

Smoker	Yes	No	Occasional
Alcohol	Yes	No	Occasional

Current Condition

Please describe your current condition & symptoms: _____

_____

_____

_____

How long have you had this condition? _____

How did it start? _____

_____

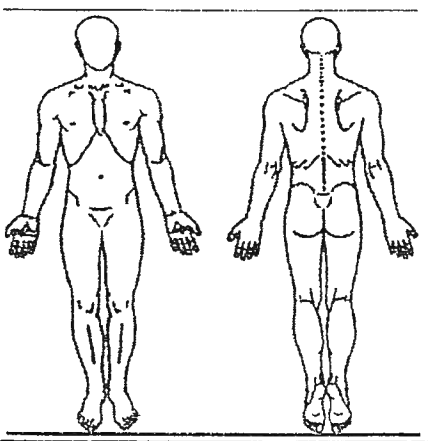
What aggravates it? _____

_____

What relieves it? _____

_____

Please indicate on the diagram the nature of your symptoms, using the symbols indicated:



Aching	O O
Stabbing	X X X
Shooting	→ →
Burning	# # #
Numbness or Tingling	≈ ≈

___ **Sharing of My Patient Record:** My initials confirm that I request and authorize my RMT to provide to the Clinic and to other health care practitioners who provide me with treatment, copies of any patient record created by my RMT. I understand this will enable the Clinic to maintain a complete patient record on my behalf. I understand that I may revoke this permission in writing at any time in the future.

Please Note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

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:** _____