

PITT MEADOWS WELLNESS CENTRE

...experience life!



604-465-1624

REGISTERED MASSAGE THERAPY- MEDICAL CASE HISTORY

Today's Date: _____

Name: _____ Date of Birth (mm/dd/yyyy): _____

Address: _____ F M Care Card #: _____

City: _____ Prov: _____ Postal: _____

Phone #(s): _____

Email: _____ Employer: _____

Referred by: _____ Occupation: _____

WorkSafe BC: Is this or may it be a WorkSafe BC claim?

- YES
 NO

Unfortunately our RMT's **DO NOT** accept WorkSafe BC Claims, even if WorkSafe BC approves treatment for Massage Therapy.

ICBC: Is this or may it be an ICBC claim?

- YES
 NO

Our RMT's **DO** accept ICBC claims however **YOU** must pay for the treatment & submit the receipts to ICBC for possible reimbursement.

PLEASE INDICATE IF YOU KNOW, OR ARE UNSURE IF ANY OF THE FOLLOWING APPLY TO YOU.

- | | |
|--|---|
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Jaw Pain |
| <input type="checkbox"/> Kidney Condition | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Circulatory Condition | <input type="checkbox"/> Fractures |
| <input type="checkbox"/> Respiratory Condition | <input type="checkbox"/> Fainting / Dizziness |
| <input type="checkbox"/> Hepatitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> H.I.V. (+) | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Infectious / Contagious Condition | <input type="checkbox"/> Diabetes Class _____ Insulin Diet |
| <input type="checkbox"/> Neurological Condition | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Pressure: High or Low | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Spinal Injury | <input type="checkbox"/> Do You Wear Corrective Eye Wear? |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Currently Pregnant: Due Date _____ |
| <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Skin Conditions _____ |
| <input type="checkbox"/> Headaches: Migraine or Tension | <input type="checkbox"/> Other Conditions _____ |

ADDITIONAL INFORMATION

ARE YOU PRESENTLY TAKING ANY MEDICATIONS?

- Pain Killers Muscle Relaxants Anti-Inflammatory Cold medications
 Other (If yes, indicate what type of Medication) _____

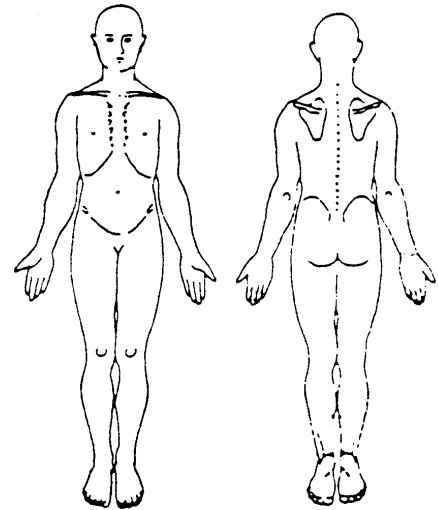
ARE YOU CURRENTLY SEEING ANOTHER PRACTITIONER?

- Massage Therapist Physiotherapist Chiropractor Other: _____

HAVE YOU HAD ANY MAJOR ACCIDENTS, ILLNESS OR SURGERY? YES NO

If Yes, please explain briefly & give dates _____

Please explain the nature of your present condition. i.e. locations and nature of discomforts, duration, frequency, activities that affect this condition, etc. Describe as accurately as you can your reason for coming here today & indicate the involved areas on the diagram below.



PLEASE NOTE

Your appointment time is reserved for you. If it is necessary to reschedule an appointment, please allow 24 hours notice, otherwise a charge of \$25 per ½ hr. (barring any emergency) will be applied.

Signature _____

Date _____

Thank you for taking the time to fill out this case history form. It will greatly assist our therapists in their assessment of your condition and help to create a treatment plan.