

CONFIDENTIAL PATIENT HISTORY FORM



Lee Taschuk, RMT
Registered Massage Therapist
P: 250.832.9651



SAFE, SMART, EFFECTIVE HEALTH CARE

Name:		PHN:
Address:		ICBC:
Home Phone:	Date of Birth:	DOI:
Alternate Phone:	Doctor:	Adjuster:
Occupation:		ICBC Claim: Yes___ No___

ICBC

If ICBC accepts your claim, they will pay part of your treatment. There will be an initial visit surcharge of \$42.00, and subsequent treatments will be \$32.00 for each visit, which you are responsible for. Payment is expected at time of treatment.

Are you receiving Premium Assistance through the B.C. Medical Plan?

- Yes** - There is an initial visit fee of \$42.00. Subsequent visits will be \$32.00. (Only 10 collective treatments are covered)
- No** - There is an initial visit fee of \$65.00. Subsequent visits will be \$55.00 for 45 minutes, \$65.00 for 1 hour.

Please indicate if you believe if any of the following apply to you? (P = past C = current) Circle if necessary.

- | | | |
|---|--|--|
| <ul style="list-style-type: none"> - Heart Attack - High / Low Blood Pressure - Stroke or Aneurysm - Pace Maker - other Heart condition - Varicose Veins - Bruise easily - other Circulatory condition - Diabetes - Kidney Disease - other Urinary condition | <ul style="list-style-type: none"> - Headaches / Migraines - Dizziness / Fainting - Nausea - Spinal Injury - Head Injury - Epilepsy / other seizures - other Neurological condition - Asthma - Chronic Sinusitis - other Respiratory condition - Irritable Bowel / Colitis - Digestive condition - Skin condition | <ul style="list-style-type: none"> - Joint Dislocation - Bone Fracture - Arthritis - Osteoporosis - Rods / Pins / Plates / Shunts - Implants _____ - Transplant _____ - Corrective Lenses/Contacts - Cancer _____ - Hepatitis - HIV - other Contagious condition |
|---|--|--|

Please list any Medications you presently take:

Known Allergies (including medications, 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, illnesses, or surgeries? Yes No

Please comment: _____

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

<input type="checkbox"/> Massage Therapy	Date of last visit _____	Location _____
<input type="checkbox"/> Chiropractor	“ _____	“ _____
<input type="checkbox"/> Physiotherapy	“ _____	“ _____
<input type="checkbox"/> Naturopath	“ _____	“ _____
<input type="checkbox"/> Acupuncture	“ _____	“ _____
<input type="checkbox"/> 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	Hours of sleep per night (approx.)	_____
Energy Level	1	2	3	4	5	Number of meals you regularly eat per day	_____
Eating Habits	1	2	3	4	5	Number of times you exercise per week	_____
Stress Level	1	2	3	4	5		
Exercise Habits	1	2	3	4	5		
Smoker	Yes	No	Occasional				
Alcohol	Yes	No	Occasional				

Current Condition

Please describe your current condition & symptoms: _____

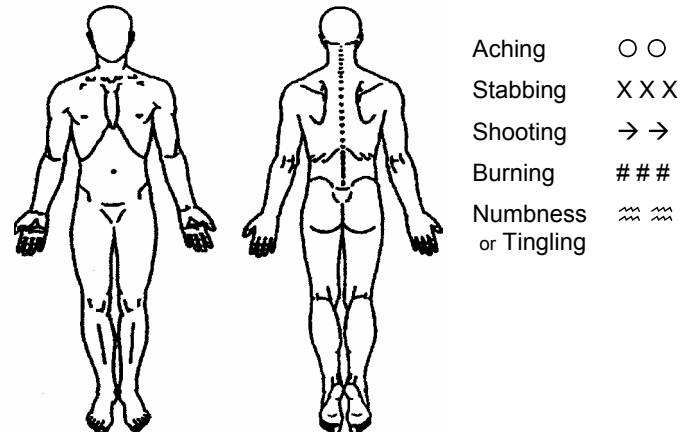
How long have you had this condition? _____

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	○ ○
Stabbing	X X X
Shooting	→ →
Burning	# # #
Numbness or Tingling	≈ ≈ ≈

Assignment of Medical Services Plan Benefits:

I agree to assign my Medical Services Plan reimbursement for Massage Therapy to Salmon Arm Massage Therapy in lieu of payment at the time of service. I further authorize Salmon Arm Massage Therapy to sign, endorse and/or negotiate any payments in connection with the treatment.

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: _____