CONFIDENTIAL PATIENT HISTORY

CONSENT TO TREATMENT

Kathryn Hodgson Massage Therapy

Name _____
Address _____
_____
Postal code _____
Phone home _____
mobile _____
work _____
Email _____

Occupation _____
Birthdate _____ day/month/year _____
Family Doctor _____
Phone _____
Health Care # _____
Referring Health Provider _____
ICBC Claim # _____
WCB Claim # _____

Please **CHECK** any of the following conditions that apply or have applied to you:

□ Heart Attack
□ High Blood Pressure
□ Low Blood Pressure
□ Stroke or Aneurysm
□ Pace Maker
□ Other Heart condition
□ Bruise easily
□ other Cardiovascular condition

□ Headaches/Migraines
□ Dizziness/ Fainting
□ Nausea
□ Spinal Injury
□ Head Injury
□ Epilepsy
□ other Seizure disorder
□ other Neurological conditions

□ Joint dislocation
□ Bone Fracture
□ Sprains
□ Arthritis (OA/RA)
□ Osteoporosis
□ Implants
□ Transplants
□ Rods/Pins/Plates/Shunts

□ Diabetes (Type I or Type II)
□ Kidney Disease
□ other Urinary condition
□ other Kidney Condition

□ Asthma
□ Chronic Sinusitis
□ other Respiratory Condition
□ Rheumatoid Arthritis

□ Cancer _____
□ Hepatitis
□ HIV
□ other contagious condition
_____

□ Depression/Anxiety
□ Insomnia/Sleep disorders
□ PTSD

□ Digestive Conditions
_____
□ Pregnancy

□ Skin Condition
□ Corrective Lenses/Contacts
□ Other conditions not listed
_____

Please list any **medications** & non-prescription vitamins/supplements you are currently taking _____
_____
_____
_____

Known **Allergies** (e.g., medications, food, seasonal, oils, lotions) _____
_____

Please list any serious accidents, injuries or surgeries with their associated dates _____
_____
_____

Please list any other therapy or treatments you receive/health professionals you see or have seen (e.g., acupuncture, chiropractor, naturopath, physiotherapy) _____
_____

Please list any activities, sports, or hobbies (e.g., jogging, soccer, crafts, computer work) _____

_____

_____

Please circle the answer closest to how you presently feel
(1 = poor 5 = excellent)

Quality of Sleep	1	2	3	4	5	approx. # hours sleep/ night_____
Energy Level	1	2	3	4	5	
Eating Habits	1	2	3	4	5	# of meals/day you eat regularly_____
Stress Level	1	2	3	4	5	
Exercise Habits	1	2	3	4	5	# of times/week you exercise_____

Are you a **smoker**? Yes No Occasional

CURRENT CONDITION
Please describe your current condition and symptoms_____

_____

_____

_____

How long have you had this condition?_____

What triggered it?_____

_____

What aggravates it? _____

_____

What relieves it?_____

_____

When does the condition feel the worst?_____

Does the condition prevent you from sleeping?_____

Declaration:
I hereby declare that the above information is accurate and complete to the best of my knowledge. I have disclosed all relevant past and present health information and agree to inform Kathryn Hodgson, RMT of any changes to the above information. I authorize Kathryn Hodgson to collect my personal information in order to contact me and to leave messages regarding appointments at any of the contact numbers / addresses I have provided above. I also authorize Kathryn Hodgson to collect my medical information as documented above and in future treatment sessions. In addition, I authorize Kathryn Hodgson to communicate with my referring MD or professional as deemed necessary for my beneficial treatment. I fully understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission. Finally, I consent to massage therapy treatment from Kathryn Hodgson.

Signature:_____ Date: _____