



**CONFIDENTIAL PATIENT HISTORY FORM**

Name \_\_\_\_\_

Birth date \_\_\_\_\_

Address \_\_\_\_\_

Family Doctor \_\_\_\_\_

Postal Code \_\_\_\_\_

Referring Professional \_\_\_\_\_

Phone (home) \_\_\_\_\_

phone \_\_\_\_\_

(cell) \_\_\_\_\_

phone \_\_\_\_\_

(work) \_\_\_\_\_

Email \_\_\_\_\_

Care Card # _____
Extended Medical Insurer: _____
ICBC or WCB?                      Yes                      No
Claim # _____

Occupation \_\_\_\_\_

How did you hear about New Leaf Massage and Wellness?

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

- |                           |                                 |                                 |                    |
|---------------------------|---------------------------------|---------------------------------|--------------------|
| - Heart Attack            | - Spinal Injury                 | - Digestive condition           | - Cancer           |
| - High/Low Blood Pressure | - Dizziness/Fainting            | - Skin condition                | _____              |
| - Stroke or Aneurysm      | - Nausea                        | - Joint Dislocation             | - Hepatitis        |
| - Pace Maker              | - Head Injury                   | - Bone Fracture                 | - HIV              |
| - Heart Condition         | - Epilepsy / other seizures     | - Arthritis                     | - other contagious |
| - Varicose Veins          | - other Neurological conditions | - Osteoporosis                  | condition          |
| - Bruise easily           | - Asthma                        | - Rods / Pins / Plates / Shunts | _____              |
| - Kidney Disease          | - Chronic Sinusitis             | - Implants                      | _____              |
| - Urinary condition       | - Respiratory condition         | - Transplants                   | _____              |
| - Headaches/Migraines     | - Irritable Bowel / Colitis     | - Corrective Lenses / Contacts  |                    |

**Please list any Medications/ Vitamins/Minerals you presently take:**

\_\_\_\_\_

\_\_\_\_\_

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

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

Please comment: \_\_\_\_\_

**Please indicate if you have received any of the following this year:**

Massage Therapy \_\_\_      Chiropractic \_\_\_      Acupuncture \_\_\_      Physiotherapy \_\_\_

**List any Activities, Sports, Hobbies** (i.e Jogging, Hockey, Crafts, Computer, ect):

\_\_\_\_\_

**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	Smoker	Yes      No      Occasional
Exercise Habits	1	2	3	4	5	Alcohol	Yes      No      Occasional

**Current Condition**

Please describe your current condition & Symptoms:

\_\_\_\_\_  
\_\_\_\_\_

How long have you had this condition: \_\_\_\_\_

How did it start: \_\_\_\_\_

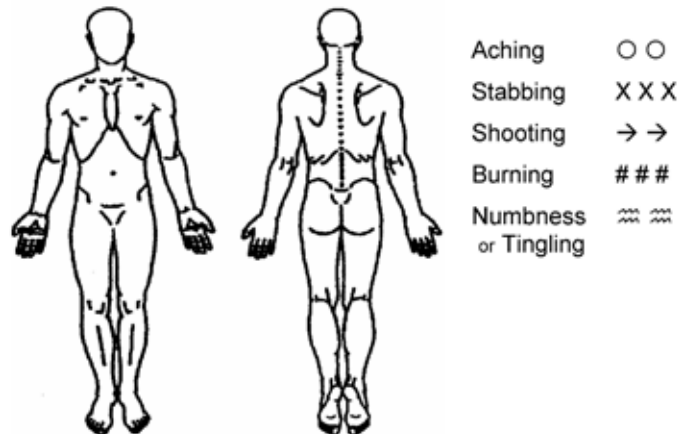
What aggravates it: \_\_\_\_\_

\_\_\_\_\_

What relieves it: \_\_\_\_\_

\_\_\_\_\_

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



**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 treatments, whether private or insured, is ultimately the responsibility of the patients. Late cancellation fees will be 50% of scheduled appointment time. Under one hour notice OR no show will be charge full appointment fee.

I authorize the clinic and its associated health care professionals 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 health care professionals to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my person and medical information is confidential and will only be disclosed to third parties with my permission

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_