



**Regina Rehab
& Family Medical Clinic**

**5950 Rochdale Blvd.
Regina, Sk. S4X 4J7
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Massage Therapy Confidential Patient History Form

Last Name: _____ First Name: _____
Address: _____
City: _____ Postal Code: _____
Phone #'s: H () - _____ C () - _____
 W () - _____ e-mail - _____
Provincial Health #: _____
Date of Birth: (date/ month/ year) ___ / ___ / ___ Age: _____
Sex: M / F Height: _____ Weight: _____
Next of Kin: _____ Relationship and Phone#: _____
Number of Children: _____ Ages: _____

-----Workplace-----

Occupation: _____
Employer: _____

-----Lifestyle-----

Currently pregnant: Y / N If yes, due date? _____
How active are you? Very active __ Active __ Moderately Active __
 Non-Active __
How much water do you drink per day? _____
Hobbies and recreation: _____
Do you take any vitamins: _____
Do you smoke? Y / N Do you consume alcohol? Y / N Avg. # drinks/ wk _____

-----Health Care-----

Referred By: _____
Family Physician: _____
 Address: _____
Did the current condition result either as a motor vehicle accident or at work? Y / N
Insurance Coverage: (Claim number and adjuster's name)
SGI: _____ WCB: _____
Other: _____

Are you seeing or previously been see by any of the following?

- () Specialist Name(s): _____
- () Chiropractor Name(s): _____
- () Massage Therapist Name(s): _____
- () Physio Therapist Name(s): _____
- () Other Therapies Name(s): _____

-----**Medical Information**-----

Are you presently under medical treatment for any reason or have any other health concerns? _____

Are you presently taking any medications? (Prescription or over the counter) (dosages)

Have you had any major surgeries and / or serious illnesses? (Details please)

Have you had any accidents or injuries? (Details please) _____

Are there any emotional/psychological issues that you feel are holding you back, or that you would like to deal with? (Details please) _____

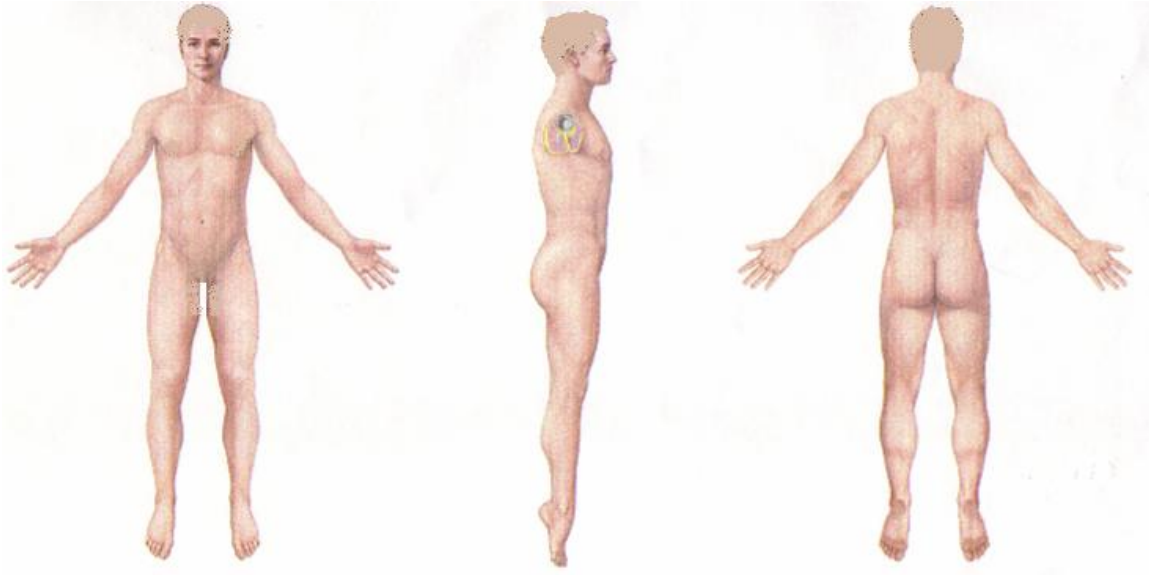
-----**Health History Questions**-----

Have you ever, or are you presently being treated for any of the following conditions?

	Present/past		Present/past
Rheumatoid/ Osteo Arthritis	() ()	Diabetes	() ()
Phlebitis/ Thrombosis	() ()	Cancer/ Tumor(s)	() ()
High/ Low Blood Pressure	() ()	Kidney Disease	() ()
Osteoporosis	() ()	Liver Disease	() ()
Heart Disease/ Heart Conditions	() ()	Crohn's Disease	() ()
Circulatory Conditions	() ()	Epilepsy	() ()
Cardiovascular System		Integumentary System	
Headaches/ Dizziness	() ()	Skin Infections	() ()
Varicose Veins	() ()	Acne/ Cysts	() ()
Immune System		GU- Women	
HIV	() ()	Menstrual Cramps	() ()
Frequent Cough/Congestion	() ()	Pelvic Inflammatory Disease	() ()
Frequent Illness	() ()	Pelvic Infection	() ()
Sinus problem/ Allergies	() ()	GU- Men	() ()
Frequent Infections	() ()	Prostate/ Urinary Infections	() ()
Musculoskeletal System		Psychiatric/ Nervous System	
Back Injury	() ()	Anxiety	() ()
Neck Injury	() ()	Depression	() ()
Whiplash	() ()	Fear	() ()
Fibromyalgia	() ()	Weakness	() ()
Jaw/ Ear Pain	() ()	Tremors	() ()
Strains/ Sprains	() ()	Phobias	() ()
Dislocation/ Fracture	() ()	Other:	

-----Reason For Treatment-----

1. Where is your pain? Please indicate on the pictures below



2. When did the pain begin? _____
3. What does the pain feel like? a) Stabbing____ b) Aching____ c) Burning____
d) Throbbing____ e) Dull____ f) Other____
4. Is the pain: a) Constant / Intermittent b) Local / Radiating / Both c) Other____
5. Is there any: Numbness / Tingling / Pins & Needles
If so, where: _____
6. Does the pain interfere with your everyday activities? If so, what? (Ex: Walking, shoulder checking, lifting...) _____
7. Does the pain interfere with any of the following? a) Sleep b) Appetite c) Nerves
8. The pain is aggravated by: _____
9. The pain is relieved by: _____
10. Does the pain worsen or lessen throughout the day? _____

I authorize Regina Rehab and Family Medical Clinic to release or obtain any information pertaining to my condition(s) and/ or treatment to/ from my other caregivers or third party payers. The information above is true to the best of my knowledge.

Signed: _____
Dated: _____