THE ALBERTA HEALTH INSTITUTE

Suite 101, 1422 Kensington Road N.W.
Calgary, Alberta T2N 3P9
Phone 521-5234 Fax 521-5237

To help our therapists accurately assess your condition, please provide us with the following information.

All information is confidential and is required to ensure that there are no contradictions to Massage Therapy.

Confidential Patient Health Record (Part 1)

PERSONAL HISTORY

NAME: _____ SEX: M F

ADDRESS: _____

CITY/PROVINCE: _____ POSTAL CODE: _____

PHONE NUMBER Res: _____ Bus: _____

EMAIL _____ BIRTH DATE: _____ AGE: _____
(dd/mm/yy)

OCCUPATION: _____

RECOMMENDED TO THIS OFFICE BY: _____

Confidential Patient Health Record (Part 2)

CURRENT HEALTH CONDITION

Purpose of this Appointment: _____

Major Complaint: _____

Describe Any Symptoms Noticed: _____

When Did This Condition Begin: _____

Have you received treatment for this condition by any of the following health care professionals?

MEDICAL DOCTOR (General Practitioner or Specialist)

Name: _____ Date of last visit: _____

MASSAGE THERAPIST

Name: _____ Date of last visit : _____

CHIROPRACTOR

Name: _____ Date of last visit : _____

PHYSIOTHERAPIST

Name: _____ Date of last visit : _____

OTHER

Name: _____ Date of last visit : _____

Have you used any of the following to alleviate your condition? What makes it feel better? (please circle)

- o Heat and/or Ice
- o Muscle Relaxants
- o Anti-inflammatories
- o Corrective Exercises
- o Remedial Stretching
- o Other _____

What makes it feel worse? _____

Are there family members with this same or similar condition? _____

Medications you now take: _____

Known allergies: _____

Do you suffer from any condition other than that which you are now consulting us?

_____

Confidential Patient Health Record (Part 3)

PAST HEALTH HISTORY

Check any of the following conditions you have had (present or past).

MUSCULO-SKELETAL

- o Low Back Pain
- o Shoulder/Arm Pain
- o Neck Pain
- o Joint Pain/Stiffness
- o Problems with Movement
- o Difficulty Chewing
- o Clicking Jaw
- o General Stiffness

NERVOUS SYSTEM

- o Nervous
- o Numbness
- o Paralysis
- o Dizziness
- o Forgetfulness
- o Fainting
- o Convulsions
- o Cold/Tingling Extremities
- o Stress

EYE-EAR-NOSE-THROAT

- o Vision Problems
- o Dental Problems
- o Ear Aches
- o Difficulty Hearing
- o Sinus Problems

GENERAL

- o HIV
- o AIDS
- o Hepatitis
- o Fatigue
- o Allergies
- o Insomnia
- o Headaches
- o Fever

CARDIO-VASCULAR

- o Chest Pain
- o Shortness of Breath
- o Heart Problems
- o Blood Pressure Problems
- o Lung Problems/Congestion
- o Varicose Veins
- o Edema (swelling of extremities)
- o Blood Clots
- o Stroke

GASTRO-INTESTINAL

- o Poor/Excessive Appetite
- o Excessive Thirst
- o Frequent Nausea
- o Vomiting
- o Diarrhea
- o Constipation
- o Abdominal Cramps
- o Liver Problems
- o Gallbladder Problems
- o Colon Problems

GENITO-URINARY

- o Kidney or Bladder Problems
- o Painful or Excessive Urination
- o Discolored Urine

FAMILY HISTORY

- o Diabetes
- o Cancer
- o Heart Disease
- o Stroke
- o Arthritis

Please list activities in which you participate:

Activity	Times per Week
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

PLEASE NOTE

CANCELLATION POLICY

12 Hours Cancellation Notice is required and in the case of missed appointments and late cancellations, you will be required to pay the full fee amount.

CONSENT TO TREATMENT

I hereby request and consent to the performance of Massage Therapy for myself by the Massage Therapist(s) below.

I have stated all my known medical conditions and take it upon myself to keep the Massage Therapist(s) updated on my physical health.

I understand that massage is given here for the purpose of stress reduction, relief from muscular tension, spasm and/or pain and for increasing circulation and energy flow.

Signature: _____

Therapist(s): _____

Witness: _____

Date: _____