# ICBC (RMT) Patient Intake Form

**Westcoast Forest Therapeutics**
1090 Howe Street, Vancouver, BC V6Z 1P5

Patient First Name: _____ Last Name: _____

Address: _____

Date of Birth (dd/mm/yy): _____/_____/_____ Sex: ☐Female , ☐Male

Cell No.: _____ Home Tel: _____ Work Tel: _____

Email: _____

Emergency Contact:_____ Tel:_____

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Please complete this form in order to assist us in becoming with your health history, and to ensure that massage therapy services provided are not contraindicated for you.
Please check ☑ if any of the following apply to you:

**General**
- ☐ Allergies_____
- ☐ Depression/Anxiety
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Headaches
- ☐ Loss of sleep (insommnia)
- ☐ Weight loss/gain
- ☐ Other_____

**Muscle/Joint/Bone**
- ☐ Osteo/Rheumatic Arthritis
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Muscle Weakness
- ☐ Neck Pain
- ☐ Osteoporosis
- ☐ Sore/Achy
- ☐ Stiff/Tight
- ☐ Other_____

**Skin**
- ☐Bruise easily
- ☐Eczema
- ☐Hives/Rash
- ☐Psoriasis
- ☐Other_____

**Cardiovascular**
- ☐Anemia
- ☐Arteriosclerosis
- ☐Poor Circulation
- ☐Edema_____
- ☐Heart Disease_____
- ☐High/Low Blood Pressure
- ☐Pace Maker
- ☐Rapid/Irregular Pulse
- ☐Rheumatic Fever
- ☐Post Stroke
- ☐Varicose Veins

Swelling of ankle ☐R ☐L

- ☐Other_____

**Women**
- ☐Menopause

Pregnant ☐Yes ☐No

If yes # months: _____

- ☐Breast Conditions_____

**Respiratory**
- ☐Emphysema
- ☐Asthma
- ☐Bronchitis
- ☐Pneumonia
- ☐Chronic Cough
- ☐Chest Pain
- ☐Other_____

**Nervous System**
- ☐Multiple Sclerosis
- ☐Numbness/Tingling
- ☐Epilepsy
- ☐Parkinson's Disease
- ☐Other_____

**Genitourinary**
- ☐Bladder Infection
- ☐Incontinence
- ☐Kidney Disorder

**Gastrointestinal**
- ☐Peptic Ulcer
- ☐Abdominal Pain
- ☐Constipation
- ☐Diarrhea
- ☐Heart Burn
- ☐IBS/Chrohn's/Colitis

**Systemic Disorders**
- ☐Cancer_____
- ☐Fibromyalgia
- ☐Diabetes (type____)
- ☐Post Polio Syndrome
- ☐HIV/AIDS
- ☐Thyroid Disease
- ☐Other_____

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1. Are you currently receiving treatment from any of the following healthcare practioners?
   ☐Chiropractor, ☐Massage Therapist, ☐Medical Doctor, ☐Physiotherapist, ☐Acupuncturist, ☐Traditional Medicine, ☐Other____
2. Have you had a bad/negative reaction to heat or cold? ☐Yes ☐No
3. When was your last physical exam? _____
4. How is your stress level? ☐High ☐Medium ☐Low
5. How is most of your day spent? ☐Standing ☐Sitting ☐Other_____
6. Do you do exercise regularly? ☐Yes ☐No

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Patient information is considered strickly confidential under the guidelines of the **Personal Information Protection and Electronic Documents Act** (PIPED)

Give a brief detailed description of the problem you are currently experiencing: _____

_____

_____

How long have you had this condition? _____ Is it getting ☐worse/ ☐better?_____

Does it bother you: ☐work, ☐sleep, ☐other: _____

What seemed to be the initial cause? _____

Are you currently satisfied with your:

- . Physical health & fitness? ☐Yes ☐No
- . Mental and emotional happiness? ☐Yes ☐No
- . Diet? ☐Yes ☐No
- . Ability to relax? ☐Yes ☐No

| Have you ever: | Yes | No | If yes explain briefly |
|---|---|---|---|
| . Been hospitalized (surgeries etc.) | ☐ | ☐ | _____ |
| . Suffered from depression/anxiety | ☐ | ☐ | _____ |
| . Had any broken bones: | ☐ | ☐ | _____ |
| . Had any strains or sprains? | ☐ | ☐ | _____ |
| . Used orthotics | ☐ | ☐ | _____ |

Please list any medications you are currently taking and why:

_____

_____

_____

Alcohol, tobacco and recreational drug use: _____

How did you know about our clinic?

☐Friend, ☐Co-worker, ☐Family, ☐Advertising, ☐Doctor, ☐Other

Is there anything else I should know?

_____

**Consent and Release:**

I wish to rely on the health practitioner to exercise judgment during the course of treatment. I also understand that the results may vary and are not guaranteed; therefore, as such there is no refund for treatments.

Anyone wants to get the patient information who must provide the written consent of the patient except the court order.

I have read the above disclaimer and stated conditions of receiving treatment. By signing below, I agree to the registered massage therapist's treatment plan.

**Signature:** _____ **Date:** _____

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