Laura Stevenson, RMT

Confidential Client Information and Health History Form

Name: _____ Date of Initial Visit: _____

Address: _____ Postal Code: _____

Date of Birth: (DD/MM/YYYY): _____ Email: _____

Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Occupation: _____

Physician Name and Telephone #: _____

Emergency Contact/ Relationship/ Phone #: _____

Which treatment modalities have you received previously:

Massage ☐ Chiropractic ☐ Acupuncture ☐ Orthotics ☐ Physiotherapy ☐ Other ☐

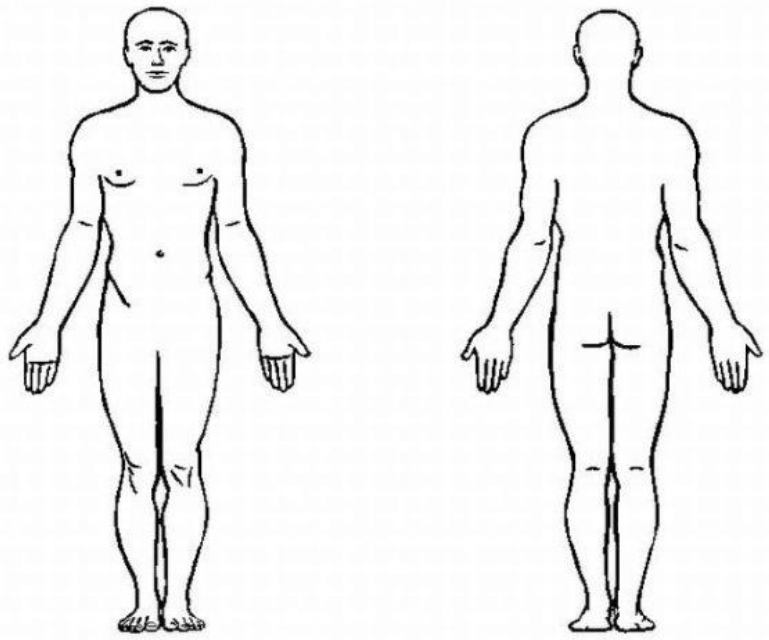
How did you hear about Laura Stevenson, RMT: _____

List of Medications/ Supplements: _____

Any medications taken today? Yes ☐ No ☐ If yes, what and how long ago? _____

Please mark on diagram and/or list the issues that bring you in today:

-
-
-
-
-
-



How would you rate your pain? (no pain) 0----1----2----3----4----5----6----7----8----9----10 (extreme pain)

Is it consistent ☐ frequent ☐ occasional ☐ infrequent ☐ Does it travel/move around? Yes ☐ No ☐

What relieves your pain? _____

What aggravates your pain? _____

Please check what applies to you regarding your health history, past and present:

Cardiovascular

_ high blood pressure
_ low blood pressure
_ congestive heart failure
_ heart attack
_ phlebitis/ varicose veins
_ stroke/aneurysm, cerebrovascular event
_ pacemaker or similar device
_ heart disease
_ high cholesterol
_ anemia
_ varicose veins
_ phlebitis
_ edema/swelling
_ hemophilia

Respiratory

_ chronic cough
_ shortness of breath
_ bronchitis
_ asthma
_ emphysema
_ sinus issues

Head/Neck

_ history of headaches
_ history of migraines
_ vision problems/ loss
_ ear problems
_ earaches/ringing in ears
_ hearing loss
_ whiplash

Infections

_ hepatitis (A/B/C)
_ TB
_ HIV/ AIDS
_ herpes
_ plantar warts
_ polio
_ eczema/ psoriasis
_ pelvic inflammatory disease
_ skin conditions: _____

Multiple Body Systems

_ kidney disease
_ bladder issues
_ liver/ gall bladder
_ Crohns/ colitis
_ fibromyalgia
_ multiple sclerosis
_ scoliosis
_ irritable bowel
_ ulcers
_ digestive issues
_ bruises easily
_ osteoporosis/ osteopenia

Other Conditions

_ loss of sensation, where? _____
_ diabetes, type, onset _____
_ allergies/ hypersensitivity to what? _____
_ type of reaction _____
_ cancer, where? _____
_ pins, rods, artificial joints _____
_ epilepsy
_ arthritis (osteo./rheumatoid)
_ depression
_ anxiety
_ sleep disturbances
_ chronic fatigue
_ stress
_ fainting/ dizziness
_ alcohol consumption
_ smoker (current/past)

Is there a family history of any of the above

☐ No ☐ Yes, specify:

_____

Women

_ Pregnant, due: _____
_ Gynecological conditions, what? _____
_ Do you suffer from PMS: Yes / No
_ Are you taking an oral contraceptive (OCP): Yes / No

Is your current injury/complaint the result of a:

MVA/car accident? □ WSIB/WSCC/workplace injury? □

Do you currently exercise? Yes □ No □ If yes, how often in hrs./week: _____

List your sports and activities: _____

Have you had any serious or chronic illnesses in the past? Yes □ No □

If yes, what and when: _____

Have you had any fractures/sprains in the past? Yes □ No □

If yes, where and when: _____

If you have hand ANY other injury/accident, please state the date & specific nature of the injury/accident:

_____

_____

If you have ever had any surgical procedure, please state the date & specific nature of that surgery:

_____

_____

Signature of Patient (or Guardian): _____ Date: _____