Joanna Bravo RMT

New Patient Information & Clinical Record

Name:		Date:
Address:		Postal Code:
Phone: (Home)	(Cell)	(Work)
Email Address:		
Date of Birth:	Care Card Number:	
Occupation:	ICBC? Claim #:	
Family Doctor:	Phone #:	
Remind me by: (circle) Text Phone Email	If text, who is your cell carrier?	

Current health complaints/ reason for consulting our office (where is your pain):

1. ______________________________ For how long? ____________________

2. ______________________________ For how long? ____________________

3. ______________________________ For how long? ____________________

Please list any medications that you presently take:

____

____

Please list any NON-prescription vitamins, minerals or other supplement you are taking:

____

____

Known Allergies: ____

____

____

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

Please Comment: ____

____

____

Please check if you are currently receiving treatment from any of the following:

Medical Doctor ☐ Chiropractor ☐ Naturopath ☐ Physiotherapist ☐ RMT ☐

What is your goal in seeking treatment for your condition (ie. Total resolution, pain free movement, etc.) ____

____

____

Are you willing to make some changes in your lifestyle, if necessary, to resolve your condition

Yes ☐ No ☐ Explain: ____

____

____

What is your daily WATER intake? (not including fruit juice, coffee, tea, soft drinks, alcohol)

2 Litres or more ☐ 1 litre ☐ 500 mL ☐ Less than 500 mL ☐

Briefly describe your diet (fast food, natural foods, etc.)

____

____

Are your bowel movements: daily ☐ less than daily ☐

Do you smoke cigarettes? How many per day? ____________________________

How often do you exercise? Daily ☐ Occasionally ☐ Never ☐

On a scale of 1 (low) to 10 (high) what is your daily energy level? ________________

On a scale of 1 (low) to 10 (high) where do you want your daily energy level to be?_______

Do you use orthotics in your shoes? ____________________

Are you pregnant? ________ If yes, what is your due date? ______________________

Menstrual Cycle: Regular ☐ Irregular ☐ Painful ☐ Heavy ☐ Menopausal ☐

Do you have children? If so how many/natural or caesarean delivery?

____

____

Please check if you presently have, or have had in the past, any of the following conditions:

	Present	Past		Present	Past
Arthritis			Epilepsy		
Contagious Disease			Fibrositis/Fibromyalgia		
Cancer			Head or Neck trauma		
Cardiovascular Disease			High Blood Pressure		
Chronic Infection			Haemophilia		
Diabetes			Kidney Disease		
Digestive Ulceration			Rheumatism		
Osteoporosis			Spinal disc injury/disease		
Tuberculosis			Skin Conditions		

Please check any of the following conditions currently bothering you:

	Slight	Moderate	Severe		Slight	Moderate	Severe
Painful muscle tension				Digestive problems			
Muscular cramps				Nausea			
Sore aching joints				Abdominal cramps			
Frequent popping sounds of joints				Painful bowel movements			
Restricted joint movement				Loss of bowel or bladder control			
Ligament sprain				Menstrual problems			
Muscle strain				Pelvic inflammation			
Joint dislocation				Urinary infection			
Pain on walking				Prostate infection			
Sore feet				Cold or flu			
Painful legs				Allergies			
Lower back pain				Asthma			
Mid-back pain				Bronchitis			
Upper back/shoulder pain				Dizziness or lite headed			
Pain in arms/wrists/hands				Cold hands/feet			
Neck pain				Excessive sweating			
Headache				Varicose veins			
Skin infection				Anxiety			
Psoriasis				Feel stressed			
Eczema				Sudden weakness			

Authorization and Consent:

Joanna Bravo, RMT will make every effort to ensure that your treatments are safe and effective. The approach to treatment may vary depending upon your condition(s). At any time before or during the treatment you have the right to ask that the treatment, or portion of the treatment, be discontinued. If you have any questions or concerns related to the treatment or techniques used we encourage you to communicate these to Joanna.

All information within your file will be kept confidential and will not be released without your prior consent.

You will be required to pay for any treatment related fees which have not been or are not covered by your health insurance or ICBC. Joanna Bravo, RMT does not accept WCB claims.

Please sign below to indicate that you have read and understood the above and that the information you provided in this case history form is accurate.

Your appointment time has been reserved for you. In courtesy of your massage therapist & fellow patients, we ask that you provide us with 24hrs notice of cancellation or a cancellation fee (full amount of the missed visit) will be charged.

______________________________ ______________________________

Signature **Date**