VITALITY TREATMENT CENTRE

302-1842 Oak Bay Avenue • Victoria, BC, Canada V8R 1C2
Phone: 250.370.1020 • www.vitalitytreatment.ca

Name: _____ Birth Date M/D/Y ___ / ___ /___ Age:____ Today's Date: _____
Sex: M / F Care Card # _____ Do you have extended medical coverage? ❒ No ❒ Yes
Do you have an active ICBC claim? ❒ No ❒ Yes Address:_____City:_____
Province: _____ Postal:_____ Home Phone:_____ Work Phone:_____
Mobile Phone:_____ E-mail: _____
Employer:_____ Occupation:_____ Medical Doctor:_____
Emergency Contact Person:_____ Relation: _____ Phone:_____
How did you hear about us: *_____*

CURRENT HEALTH CONDITION

Please describe your current condition & symptoms:

_____
_____
_____

How long have you had this condition?

_____
_____

How did it start?

_____
_____

What aggravates it?

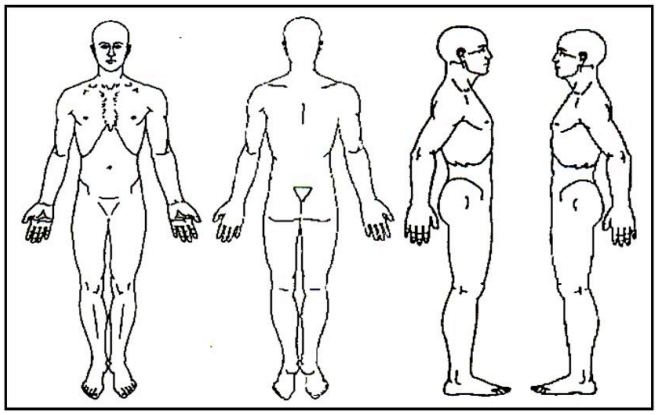
_____
_____

What relieves it?

_____
_____

Please indicate on the diagram the nature of your symptoms, using the symbols provided:

Aching **O**	*Burning* **#**	*Stabbing* **X**
Tingling **^**	*Numbness* **~**	*Shooting* **→**



How much per week do you work on average? _____ Hours _____ How do you spend most of your days?
❒ Sitting ❒ Standing ❒ Light manual labour ❒ Manual labour ❒ Hard manual labour

If you are presently taking any medications, supplements or vitamins please list their names and purpose:

_____
_____

Please list any allergies (medications, seasonal, foods, smells, oils/lotions…) _____
_____

YOUR PAST INJURIES *(motor vehicle accidents, broken bones, major surgeries, etc.)* _____
_____
_____

WOMEN ONLY:
How many pregnancies have you had? _____ How many deliveries have you had? _____ Are you pregnant now? ❒Y ❒ N How many weeks? _____ Due date? _____ One/twins/more? _____

YOUR CURRENT IDEAS & VALUES TOWARDS HEALTH:

I understand that people come to the clinic for a variety of reasons. My goal is to maximize your function and health to the greatest extent I can. What type of care are you currently interested in?

❒***Relief Care*** *Symptomatic relief of pain or discomfort without concern for underlying cause*
❒***Corrective Care*** *Symptomatic relief as well as cause of problem corrected*
❒***Wellness Care*** *Start with corrective/relief and continue maintenance to sustain the improvements gained*

YOUR PAST AND CURRENT GENERAL HEALTH :

*Please indicate if any of these apply to your health history. Check the box **P** for a **past condition** or **C** for a **current condition**.*

C	P		C	P		C	P	
❒	❒	*Arthritis*	❒	❒	*Contagious skin condition*	❒	❒	*Allergic Reactions*
❒	❒	*Bone Fracture*	❒	❒	*Eczema*	❒	❒	*Autoimmune Disease*
❒	❒	*Bursitis*	❒	❒	*Psoriasis*	❒	❒	*Cancer*
❒	❒	*Compression Syndrome*				❒	❒	*Diabetes Type 1 / 2*
❒	❒	*Degenerative Disc/Joint Disease*	❒	❒	*Kidney Disease*	❒	❒	*Fibromyalgia*
			❒	❒	*Incontinence*	❒	❒	*HIV / AIDS*
❒	❒	*Dislocation/ Subluxation*				❒	❒	*Hepatitis*
			❒	❒	*Hypothyroidism*			
❒	❒	*Ligament/ Joint Sprain*	❒	❒	*Hyperthyroidism*	❒	❒	*Constipation*
❒	❒	*Muscle Strain*				❒	❒	*Irritable Bowel*
❒	❒	*Rods/Pins/Plates/Shunts*	❒	❒	*Heart Attack*	❒	❒	*Colitis*
❒	❒	*Tendonitis*	❒	❒	*Stroke or Aneurysm*	❒	❒	*Ulcer*
❒	❒	*Transplants*	❒	❒	*Pace Maker*	❒	❒	*Hernia*
❒	❒	*Tension Headache*	❒	❒	*Heart Condition*			
			❒	❒	*High Blood Pressure*			
❒	❒	*Dizziness/ Fainting*	❒	❒	*Low Blood Pressure*			
❒	❒	*Epilepsy/ Other Seizures*	❒	❒	*Varicose Veins*			
❒	❒	*Head Injury*	❒	❒	*Bruise Easily*			
❒	❒	*Migraine Headache*	❒	❒	*Poor circulation*			
❒	❒	*Nausea*						
❒	❒	*Spinal Cord Injury*	❒	❒	*Asthma*			
			❒	❒	*Bronchitis*			
			❒	❒	*Emphysema*			
			❒	❒	*Sinusitis*			

Other Health Conditions:

_____
_____
_____
_____
_____
_____
_____

*Please **CIRCLE** the answer closest to how you **PRESENTLY** feel: (**1** = **poor**, **5** = **excellent**)*

Quality of Sleep	*1*	*2*	*3*	*4*	*5*	*Hours of sleep per night (approx.)* _____
Energy Level	*1*	*2*	*3*	*4*	*5*	
Eating habits	*1*	*2*	*3*	*4*	*5*	*Number of meals you regularly eat per day* _____
Stress Level	*1*	*2*	*3*	*4*	*5*	
Exercise Habits	*1*	*2*	*3*	*4*	*5*	*Number of times you exercise per week* _____
Water intake	*1*	*2*	*3*	*4*	*5*	

Do you smoke cigarettes?	*No*	*Yes, occasionally*	*Yes, regularly*
Do you drink alcohol?	*No*	*Yes, occasionally*	*Yes, regularly*
Do you drink caffeine?	*No*	*Yes, occasionally*	*Yes, regularly*

CANCELLATION / MISSED APPOINTMENT POLICY

*If you need to change your appointment, please give us **AT LEAST 24 HOURS NOTICE** so that we can fill the space. Should an appointment be cancelled with **less than 24 hours** notice, or **missed entirely without any notice**, the **full appointment fee** may apply. Please understand that this policy is in place because we do our best to respect you and your time and we expect the same from you in return. THANK YOU!*

Patient or Parent/ Guardian Signature: _____ *Date: M/D/Y* ____/_____/_____

PATIENT DECLARATION

I hereby grant full treatment consent to Vitality's RMTs, for the purpose of Massage Therapy treatment. I authorize the clinic and its associated RMTs to communicate with my Medical Doctor regarding concerns directly related to my massage therapy treatment. I understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission. I also understand that I am expected to notify my RMT if there are any changes to my health OR if I am uncomfortable with ANY part of the massage therapy treatments.

Patient or Parent/ Guardian Signature: _____ *Date: M/D/Y* ____/_____/_____