Tonume • Chiropractic • Naturopathic • Massage Therapy
Integrated Health

RMT Confidential Patient History Form

Tonume Integrated Health
2657 Commercial Drive
Vancouver, BC, V5N 4C3
Phone: 604 428 1399

Name: _____ **Birthdate:** _____(yyyy/mm/dd)

Address: _____ **Family Doctor:** _____

_____ **Phone:** _____

Postal Code: _____ **Referring Professional:** _____

Phone: **(home)**: _____ **Phone:** _____

(Cell): _____ **Care Card Number #**_____

(Work): _____ **Extended Health Benefits Provider:**_____

Email: _____ **Plan #**_____ **Member ID**_____

Occupation: _____ **Relationship to Policy Holder:**_____

How did you hear about our clinic? _____

I would like to be placed on the clinic email list to receive information on clinic updates and specials. Yes ☐ No ☐

We do not share/sell email addresses and are kept strictly confidential.

Please indicate if you believe any of the following apply to you

_ Heart Attack	_ Headaches / Migraines	_ Skin condition
_ High / Low Blood Pressure	_ Dizziness / Fainting	_ Pregnancy ____trimester
_ Stroke or Aneurysm	_ Nausea	_ Bone Fracture
_ Pace Maker	_ Spinal Injury	_ Arthritis
_ other Heart condition	_ Head Injury	_ Osteoporosis
_ Varicose Veins	_ Epilepsy / other seizures	_ Rods / Pins / Plates / Shunts
_ Bruise easily	_ Other Neurological condition	_ Implants
_ other Circulatory condition	_ Asthma	_ Corrective Lenses/Contacts
_ Diabetes	_ Chronic Sinusitis	_ Cancer
_ Kidney Disease	_ Other Respiratory condition	_ Hepatitis
_ Transplant	_ Other Urinary condition	_ HIV
_ Anxiety/Depression	_ Irritable Bowel / Colitis	_ Other Contagious condition
_ Pregnancy Week _____	_ Digestive condition	_____

Please list any medications you are taking: _____

_____

_____

Known Allergies (including medications, foods, seasonal, oils and lotions, etc.) _____

_____

Do you have any family history of medical conditions? Yes ☐ No ☐

Please list:_____

_____

Have you ever been hospitalized, had any major accidents, illnesses, or surgeries? ☐Yes ☐ No Please list:_____

_____

Other therapy/treatment: (past or present, does not have to be related to this visit)

☐ Massage Therapy	Date of last visit	_____	Location	_____
☐Chiropractor	"	_____	"	_____
☐Physiotherapy	"	_____	"	_____
☐Naturopath	"	_____	"	_____
☐Acupuncture	"	_____	"	_____
☐Other _____	"	_____	"	_____

List any Activities, Sports, Hobbies (ie. Jogging, Hockey, Crafts, Computer, etc)

_____

_____

_____

_____

List any NON-prescription vitamins, minerals or other supplements you are taking:

_____

_____

_____

_____

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

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	_____

Smoker	Yes	No	Occasional
Alcohol	Yes	No	Occasional

Current Condition

Please describe your current condition and symptoms:

_____

_____

_____

How long have you had this condition? _____

How did it start?

_____

_____

_____

What aggravates it?

_____

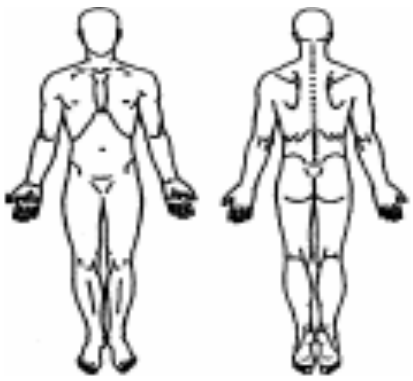
_____

What relieves it?

_____

_____

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



Aching	OO
Stabbing	XXX
Shooting	➔➔
Burning	###
Numbness Or Tingling	≈ ≈

Please Note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for the treatment, whether private or insured, is ultimately the responsibility of the patient.

I authorize the clinic and it's associated RMTS to collect my personal and medical information as documented above in order to contact me, and give permission to for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I have authorized the clinic and its associated RMTs to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to the third parties with my permission.

Signature: _____ Date: _____