**_Patient Name:_**

Heather Pierce Cormier RMT DOMP

## _Personal History_

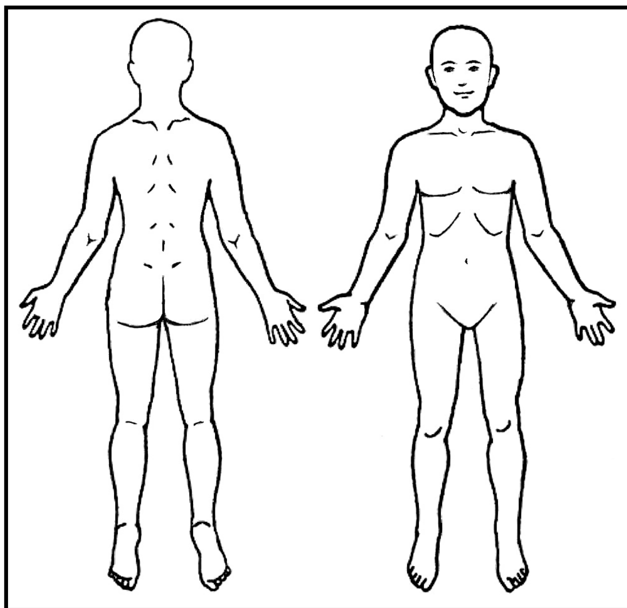
Last name: ______________ First name: ______________ Initial: ______
Mailing Address: ______________________________
City: ______________ Province: __________ Postal Code: __________
Home Phone: ______________ Cell: ______________
email: ______________ ______________
Birth date: Day ______ Month ______ Year ___ Gender Identity: ______________
Sex assigned at birth: ______ Occupation: ________ Age: ______________
Health Card Number: ______________ Medical Doctor: ______________
Hobbies/Activities: ______________________________
Who may we thank for referring you to this office? ______________________________

## _Current Health Condition_

Current Complaint(s): ______________________________
When did the condition begin? ______________ Has the condition occurred before? Yes ☐ No ☐
How did the condition begin? ______________________________
Is the condition: ☐ Job-related ☐ Auto-related ☐ Fall or Trauma ☐ Repetitive stress
Date of Accident: ______________ Time of Accident: ______________
Have you seen anyone else for this condition? ______________________________
Character of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb ☐ Burning
☐ Constant ☐ Intermittent ☐ Other: ______________________________

Place a mark (/) on the line below to indicate the severity of your pain:

_NO PAIN_ ______________________________ _WORST POSSIBLE PAIN_



**Please use the symbols provided below to outline on the diagram the area of your discomfort and any radiation of pain.**

| | |
|---|---|
| **X** | Sharp Pain |
| /// | Dull Pain |
| ::: | Numbness |
| **==** | Stiffness |
| **~~** | Burning Pain |
| | Other |

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What aggravates your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Sleeping ☐ Desk work
☐ Other: ____________________

What relieves your condition? ☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication
☐ Other: ____________________

Condition is getting: ☐ Worse ☐ Constant ☐ Comes/Goes ☐ Better

Please describe how it feels when this problem is at its worst: ____________________

***Past Health History***

Major Surgery/Operations: ☐ Back Surgery ☐ Heart Surgery ☐ Hip or Knee ☐ Other: __________

Major illness (past /present) ☐ Cancer ☐ Other: ____________________

Broken bones: ☐ Spinal fracture ☐ Leg or ankle ☐ Collar bone ☐ Other: __________

Sprained/torn ligaments ☐ Knee ☐ Ankle ☐ Shoulder ☐ Other: __________

Past Trauma: ☐ Childhood Traumas __________ ☐ Sports Injuries __________
☐ Motor Vehicle Accidents __________ ☐ Work Injuries __________

Do your wear orthotics or corrective footwear? ☐ Yes ☐ No

Have you had X-rays or an MRI/CT taken? ☐ Yes ☐ No If yes, when? ____________________

**Health History:**

**Muscle/Joint Pain**

- ☐ Neck
- ☐ Jaw
- ☐ Back (upper)
- ☐ Back (mid)
- ☐ Back (lower)
- ☐ Shoulders
- ☐ Elbow
- ☐ Wrist/hand
- ☐ Hip
- ☐ Knee Pain
- ☐ Foot / Ankle Pain
- ☐ Joint Pain / Stiffness
- ☐ Spine
- ☐ General Stiffness

**Head and Neck**

- ☐ history of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Vision loss
- ☐ Ear problems
- ☐ Hearing loss
- ☐ Major dental work

**C-V-R**

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart Attack
- ☐ Phlebitis/ Varicose Veins
- ☐ Stroke/CVA
- ☐ Pacemaker or similar devise
- ☐ Heart Disease

**Infections**

- ☐ Skin conditions
- ☐ Hepatitis
- ☐ other:

**Digestive**

- ☐ Constipation
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Irritable bowel syndrome
- ☐ Ulcers
- ☐ other:

**Respiratory**

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic cough
- ☐ Shortness of breath

**Skin Conditions**

- ☐ Eczema
- ☐ Psoriasis
- ☐ Rash
- ☐ Warts
- ☐ Open sores

**Female**

- ☐ Menstrual problems
- ☐ Menopausal problems
- ☐ Vaginal Pain / Infections
- ☐ Breast Pain / Lumps
- ☐ Pregnancy date:
- ☐ number of pregnancies:
- ☐ Hysterectomy

***Patient Name:***



**Workplace Stress Levels**

- ☐ High
- ☐ Moderate
- ☐ Very Little

**Do you have a regular exercise program?**

- ☐ Yes
- ☐ No

**Lifestyle Stress Levels**

- ☐ High
- ☐ Moderate
- ☐ Very Little

**Other**

- ☐ Loss of sensation
  Where?
- ☐ Diabetes/ Onset::
  Type
- ☐ Allergies/hypersensitivity
  What?
- ☐ Epilepsy
- ☐ Cancer
  Type/location:
- ☐ Arthritis
- ☐ Hemophilia
- ☐ Fibromyalgia
- ☐ Chronic Fatigue
- ☐ Scoliosis
- ☐ Osteoporosis

**Check the medication(s) that you take regularly**

- ☐ Insulin
- ☐ Antacids
- ☐ Heartburn medication
- ☐ Laxatives
- ☐ Arthritis medication
- ☐ Muscles relaxants
- ☐ Blood pressure medication
- ☐ Birth control pills
- ☐ Pain killers
- ☐ vitamins
- ☐ Other: _________________
  _________________
  _________________

**Why Massage Therapy and Osteopathic Care?**

People go to a Massage Therapist or an Osteopath for a variety of reasons. Some go for symptomatic relief of a condition (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible (Wellness Care). These three “phases of care” are effective drug-free, surgery-free treatment strategies for many conditions.

Knowledge and understanding is important in your recovery. Please discuss with your Massage Therapist/Osteopathic Manual Practitioner your treatment goals and desires. She will conduct a thorough history and examination to determine your program of care. She will consider your limitations and capacity, and the risk and benefits of different treatment options. If you have any questions or concerns about your condition or the recommended treatment, do not hesitate to discuss these with your Massage Therapist/Osteopathic Manual Practitioner.

**Missed Appointment and Cancellation Policy**

**We require 24 hours notice for cancellation of appointments** as we have set aside that appointment time for you. We will bill you directly the full cost of the treatment for missed appointments without adequate notice.

**Informed Consent to Massage Therapy Treatment and Osteopathic Manual Therapy**

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my massage Therapist/Osteopathic Manual Practitioner the nature and purpose of Massage Therapy and Osteopathic Manual Therapy treatment, the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the Massage Therapy and Osteopathic manual therapy treatment recommended to me by my Massage Therapist/Osteopathic Manual Practitioner.

I intend this consent to apply to all my present and future Massage Therapy and Osteopathic care.

**Dated this _________________ day of __________________, 20___.**

_________________________________

**Patient Signature (Legal Guardian)**

**Name: ______________________________**

**(please print)**