Student Wellness Services

Confidential History Form

Student ID# _____ Undergrad ____ or Graduate ____

Or check one of the following: STAFF ____ FACULTY ____ VISITOR ____

Name _____

Address: _____

City, Province: _____ Postal Code: _____

Telephone: Home _____ Cell: _____

Work: _____ E-Mail: _____

Date of Birth (D/M/Y): _____ Occupation: _____

Insurance Company and Policy_____

Provincial Health Care # _____ Province _____

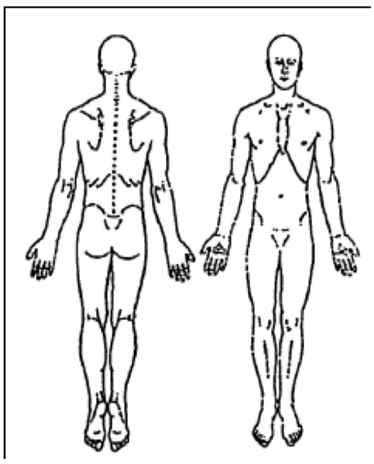
How did you find out about the clinic? _____

Is this a referral from a medical doctor? Yes __ No __ Doctor's name _____

Reason for coming in (Chief concern) _____

When did this start? _____ is it better/same/worse? _____

Indicate on the diagram where your concern is:



How intense is your pain?
(0 = no pain 10 = worst pain ever
0 _____ 10

How concerned about this are you?
(0 = no concern 10 = very concerned)
0 _____ 10

Have you ever been treated for the same/similar problem? When? _____

Please list any major injuries, accidents or trauma and the dates: _____

_____

Please list any surgeries and the dates: _____

_____

Please indicate if you have any of the following:

☐ Migraines	☐ Chronic pain	☐ Tendonitis	☐ Varicose Veins
☐ Tension headaches	☐ Numbness/tingling	☐ Bursitis	☐ Phlebitis
☐ Sleep Issues	☐ Diabetes	☐ Heart problems	☐ Allergies
☐ Joint Pain	☐ Respiratory Problems	☐ Pregnancy	☐ Arthritis-Osteo/Rheum.
☐ Low blood pressure	☐ High Blood Pressure	☐ Autoimmune condition	☐ Fatigue
☐ Lower leg pain	☐ GI/Stomach Issues		

*** PLEASE TURN PAGE OVER ***

Have you travelled recently? _____

Are you taking any medications? If so, for what? _____

_____

Do you have any ongoing or serious medical problems or disabilities? _____

_____

Have you ever had massage therapy prior to this visit? _____

If so, when? _____

Please indicate which muscles in your body usually suffer from tension, soreness, etc.

☐ Neck	☐ Shoulders	☐ Thighs/ quads
☐ Upper back	☐ Chest	☐ Hamstrings
☐ Lower back	☐ Arms	☐ Calves
☐ Hands	☐ Feet	☐ Jaw

This information is collected under the authority of the Freedom of Information and Protection of Privacy Act (FOIP). It is required to provide health service. This information will form part of you clinical file. If you have any further questions please contact the SU Wellness Centre Administrator at 403-210-8904.

Massage Therapy is an aid to help and is not a medical diagnosis. The risks associated with Massage Therapy treatments can vary according to each patient's condition, the type of treatment received and location of discomfort/pain. I further understand that the above information will assist the therapist in the type of treatment performed. All information on this form is confidential and for the exclusive use of the Massage Therapist involved. I therefore clarify that the above information is true. I understand that one business days' notice is required when cancelling any Massage Therapy appointment, or a full payment for the appointment will be required.

Signature: _____ Date: _____