

CONFIDENTIAL CASE HISTORY

Name: _____ CareCard #: _____

Address: _____ Postal Code: _____

Phone: Home: _____ Work: _____ Cell: _____

E-Mail: _____

Date of Birth: M: ___ D: ___ Y: _____ Medical Doctor: _____

Occupation: _____ Referred by: Text

Reason seeking treatment->Describe condition: _____

Onset: Sudden Gradual --Date of initial onset? _____

Cause of injury (if known): _____

Quality of pain: Sharp Burning Dull Aching Tingling Shooting Other _____

What aggravates your symptoms? _____

What relieves your symptoms? _____

Does your condition affect your daily activities? No Yes -> How? _____

Is the pain worse in the morning or the evening? _____

Are you currently seeing, or have you in the past, seen another practitioner for this condition?

Massage Therapy Chiropractic Physiotherapy M.D. Other: _____

Do you have any other areas of pain? _____

Have you had any serious injuries, accidents, surgery, illness? Please explain: _____

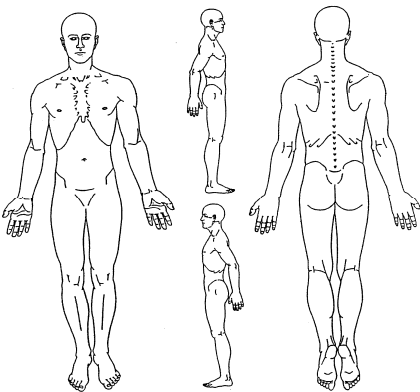
Do you engage in a fitness program? No Yes. Please describe (type of exercise/how often): _____

How would you describe your general health? Excellent Good Fair Poor

How would you rate your stress levels? Low < 0-----2-----4-----6-----8-----10 > High

Do you sleep well at night? No Yes. Average # of hours? _____

Please indicate areas of concern:



Medical History

	Present	Past		Present	Past
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Condition	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Injury	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	Aching joints	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Swollen joints	<input type="checkbox"/>	<input type="checkbox"/>
Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Smoking	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Skin Condition	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hyperkyphosis	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycaemia	<input type="checkbox"/>	<input type="checkbox"/>
Hyperlordosis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Sprains/Strains	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Dislocations	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Circulatory Condition	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Visual Problems	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	GI Problems	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Ear aches/ringing	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Condition	<input type="checkbox"/>	<input type="checkbox"/>	Liver Condition	<input type="checkbox"/>	<input type="checkbox"/>

Other: _____

Allergies (please list)

Do you have or use: arch supports/orthotics steel pins/plates prosthetics

List medications: _____

To the best of my knowledge the above is a true statement of my physical condition,

Signature: _____ Date: _____

Cancellation Policy

Please keep in mind that your treatment time is reserved specifically for you. A minimum of 24 hours notice for rescheduling or canceling appointments is required. There will be a charge of the full scheduled treatment rate for missed appointments or cancellations without 24 hours notice.

Please initial here to indicate you have read & understood this policy. _____