Brodie Brooks, RMT
Frackson Health Care | 105 - 1001 Cloverdale Avenue, Victoria, BC V8X 4C9

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):

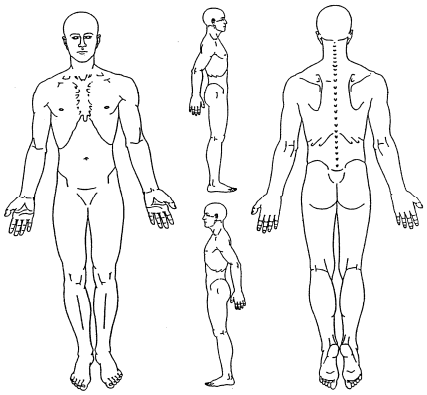
_____

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

☐ 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. _____