# CONFIDENTIAL PATIENT CASE HISTORY

Name _____ Home Phone _____

Address _____ Work Phone _____

City _____ Postal Code _____ Mobile Phone _____

E-Mail address _____ Occupation _____

Personal Health Number (MSP#) _____ Date of Birth (M/D/Y) _____

Doctor's Name _____ Dr's Phone _____

If this is a motor vehicle accident or workers compensation claim, please provide the following information:

ICBC or WCB # _____ Date of accident _____

Adjuster's Name _____ Phone Number _____

PRESENT SYMPTOMS: What is your major concern? _____

_____

_____

MINOR SYMPTOMS: Other areas of pain or concern? _____

_____

_____

What aggravates your symptoms? _____

What relieves your symptoms? _____

Is this condition getting worse? Yes____, No____, Constant____, Comes and Goes____.
Is it interfering with your: Work____, Sleep____, Daily Routine____, Other_____.
Medications: _____
X-Rays? No____, Yes____; What did they reveal? _____
Have you seen a: Chiropractor____, Physiotherapist____, Massage Therapist____, Other_____.
Have you had a similar problem before? ____. When? _____
Any serious past illness, injury operation or MVA? _____
Are you wearing: Heel Lifts____, Arch supports____, Orthotics____.
Please list regular exercise or activities: _____

| HABITS | HEAVY | MODERATE | LIGHT | NONE |
|---|---|---|---|---|
| Alcohol | ____ | ____ | ____ | ____ |
| Coffee / Tea | ____ | ____ | ____ | ____ |
| Tobacco | ____ | ____ | ____ | ____ |
| Weekly sugar consumption | ____ | ____ | ____ | ____ |

PRIORITY THERAPEUTIC MASSAGE & HEALTH

**Please turn over**

***Do you have any of the following? If yes, please circle.***

DIABETES ARTHROSCLEROSIS CANCER HEART DISEASE EPILEPSY

HEMOPHILIA INFECTIOUS OR CONTAGIOUS DISEASE HIV VIRUS

***Please circle any conditions which are a problem for you.***

**HEAD / NECK:**

Headaches Frequency and duration: _____

Vision problems Thyroid earache sinus problems

**RESPIRATORY:**

Chronic Cough Chest Pain Shortness of breath Asthma Tightness in chest

**CARDIOVASCULAR:**

High / Low Blood Pressure Poor Circulation Swelling of Ankles Stroke

Hardening of Arteries Varicose Veins Fainting Dizziness Angina

**SKIN:**

Rashes Itching Dryness Boils Hives Bruise Easily

**DIGESTION:**

Poor Appetite Loos / Gain Weight Indigestion / Nausea Belching / Gas

Constipation / Loose B.M. Kidney / Bladder Liver / Gall Bladder Ulcer

**MUSCLES AND JOINTS:**

Fractures Pins Arthritis / Rheumatism Stiff Neck Backache Tension

Pain in the: Jaw Shoulders Elbow Wrist Hand Hip Knee Ankle Feet

Tingling Numbness Radiating Pain Swollen Joints Stiffness with Movement Limitation of Movement

**Other:**_____

Are you Pregnant?_____ Due Date_____

**Referred by:** Doctor____, RMT____, Chiropractor____, Physiotherapist____, Patient____, Web Page____, Yellow Pages____, Other_____

IN CONSIDERATION TO YOUR FELLOW PATIENTS AND THE THERAPIST 24 HOURS NOTICE IS REQUIRED TO CHANGE OR CANCEL AN APPOINTMENT OR YOU WILL BE CHARGED FOR THE APPOINTMENT.

READ AND UNDERSTOOD BY (signature)_____ DATE _____