

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	_____	_____	_____	_____



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 _____