HEALTH CARE HISTORY

ALL INFORMATION IS CONFIDENTIAL

Name_____ Telephone (home)_____

Address_____ Telephone (work)_____

_____ Postal Code_____

Date of Birth_____ Occupation _____

Family Physician _____ Referred by _____

Today's Date _____ Claim # _____

Email _____ Type of Claim/Insurer _____

What is your major area of concern? _____

_____

When and How did this condition begin?_____

Was the onset sudden or gradual?_____

Is this condition constant or does it come and go? _____

Describe the quality of pain: _____sharp _____burning _____dull _____aching _____tingling

_____shooting _____other... (describe_____)

What activities aggravate this condition?_____

Is this condition interferring with your: sleep? _____ daily routine? _____ work? _____

What have you done to relieve the pain? _____

Other Symptoms: _____ grinding _____ popping _____giving way _____numbness

_____ dizziness _____weakness _____nausea _____vomitting _____none

Have you had and assessments or diagnosis by a health care professional? _____

Have you had a similar condition before? If so, give details _____

Was it resolved? _____

Do you consider massage therapy to be a component in your stress management? Yes _____ No _____

Are you currently seeing another practitioner?

_____ MD _____ Chiropractor _____Physiotherapist _____RMT _____ Other

Have you had? Describe briefly:

Surgery? _____

Bone Fractures? _____

Motor Vehicle Accidents?_____

Other Illnesses?_____

If you have ever had any of the following conditions, please check:

___heart disease	___ cancer
___arteriosclerosis	___hemophilia
___kidney disease	___ diabetes
___arthritis	___liver or gallbladder problems
___high blood pressure	___low blood pressure

Are you taking any Medications? _____No _____ Yes

What type? ____painkiller ____sleep ____depression ____muscle relaxant ____anti-inflammatory

Do you have any known allergies? _____

Do you wear/have? ___Implants ___Contact Lenses
___Arch Supports ___Steel Pins ___Other: _____

Lifestyle:	Heavy	Moderate	Light	None
Alcohol:	_____	_____	_____	_____
Coffee/Tea	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Exercise	_____	_____	_____	_____

Are you Satisfied with your:	yes	no
Ability to relax	___	___
Exercise	___	___
Energy Level	___	___
Overall Health	___	___
Sleep	___	___

SIGNATURE _____ DATE _____

Your time is valuable and so is ours. If you are unable to keep your appointment, please notify us 24 hours in advance. Otherwise, a cancellation fee may be charged …

Do you have difficulty with the following?

Cardiovascular
_____ presently experiencing fever
_____ shortness of breath
_____ repeated chest pain
_____ dizziness or fainting
_____ frequent cold hands or feet
_____ frequent tingling in lips or fingers
_____ varicose veins

Digestion
_____ continued trouble digesting
_____ gas or bloating
_____ constipation or diarrhea
_____ ulcers or acute stomach pain
_____ "heartburn" or acidic stomach
_____ loss of appetite
_____ use of laxatives
_____ hiatus hernia

Nervous System
_____ unexplained bodily weakness
_____ constant nervousness and anxiety
_____ constant tight feeling in stomach or throat
_____ perspiring hands and feet
_____ irritability
_____ depression

Musculoskeletal
_____ painful muscle tension
_____ headaches
_____ grating of neck
_____ muscle cramps
_____ twitching muscles
_____ frequent backache
_____ sore or aching joints
_____ frequent cracking or popping of joints
_____ repeated sprains or dislocations
_____ pain or difficulty walking
_____ disc problems

Immune System
_____ frequent colds or flu
_____ wounds heal slowly
_____ frequently fatigued
_____ history of swollen glands

Respiratory
_____ frequent cough
_____ frequent congestion
_____ sinus problems

Skin
_____ frequent skin infections
_____ communicable skin infections
_____ psoriasis
_____ eczema
_____ rashes
_____ bruising easily

Genito-Urinary

Women
_____ frequent or severe menstrual cramping
_____ pelvic inflammation or infection
_____ presently pregnant
_____ bladder infection
_____ menopausal symptoms

Men
_____ prostate and/or urinary infections
_____ painful urination

Sensory
_____ ringing of ears
_____ balance
_____ hearing
_____ vision
_____ memory
_____ ticklishness

Is there anything else you feel would be helpful for me to know about you?

_____

_____

_____