Westney Heights Chiropractic Centre
Massage Therapy Confidential Patient Case History Form

Please take a few moments to provide the following health history. This information will be kept confidential and will be used for no other purpose than for your therapist's clinical records. Please notify us if any of the following information changes. Thank you.

Name (please print) _____ Date _____

Address _____ City_____ Postal Code_____ e-mail _____

Home # _____ Business # _____ Cell # _____

Date of Birth (D/M/Y) _____ Height _____ Weight _____ Sex: M / F

Occupation _____ Hobbies, sports & activities _____

Name, address & phone number of physician _____

_____

Current medications and the conditions they treat_____

_____

Have you recently been in a motor vehicle accident or work related injury to which you will be making a claim? YES NO

Do you have any allergies/hypersensitivities? Yes / No If yes, please explain _____

How did you hear about our office? Phonebook □ Internet □ Sign/Location □

Patient/Professional Referral □ *(specify)* _____ Other □ (*specify*)_____

What are the reasons you are seeking massage therapy?_____

Are your symptoms? DULL SHARP SHOOTING ACHY NUMB TINGLING STIFF

Pain scale: (low) 0----------5----------10 (high) Does the pain travel anywhere? _____

Does anything aggravate your symptoms? _____

Does anything relieve your symptoms? _____

When did your symptoms begin? _____

Have they changed and how? _____

Is this condition interfering with: WORK SLEEP DAILY ROUTINE ACTIVITIES

(Explain) _____

Have you seen any other health care practitioners concerning this complaint: Medical Doctor □ Chiropractor □

Physiotherapist □ Massage Therapist □ Other □ _____

Have they provided results or a diagnosis? _____

Any surgeries/injuries/hospitalization? (*date, describe*) _____

_____

Do you have any internal pins/wires/artificial joints/special equipment? _____

HEALTH HISTORY Please check conditions you are experiencing or have experienced in the past.

INFECTIOUS CONDITIONS

Tuberculosis Yes □ No □
AIDS/HIV Yes □ No □
Hepatitis Yes □ No □
*Type*_____
Infectious skin condition(s) Yes □ No □
_____

HEAD / NECK

Headache □
Migraine □
Visual loss/disturbances □
Contact lenses/glasses □
Ear aches/conditions □
Hearing loss/problems □
Jaw pain/dental problems □
Whiplash □

CARDIOVASCULAR

High blood pressure □
Low blood pressure □
Chronic Congestive Heart Failure □
Poor Circulation □
Heart disease □
Phlebitis □
Varicose veins □
Stroke/TIA/CVA □
Heart attack □
Pacemaker/similar device □
Arteriosclerosis □
Irregular heart beat □

RESPIRATORY

Asthma □
Chronic cough □
Shortness of breath □
Bronchitis □
Emphysema □
Smoker □

DIGESTIVE / URINARY

Difficult digestion □
Constipation □
Liver / Gallbladder □
Kidney / Urinary bladder □
Diabetes (type & onset) _____ □
Hypoglycemia □
Crohn's/Colitis □
Irritable bowel □
Ulcers □

SKIN

Bruise easily □
Eczema □
Psoriasis □
Sensitivity □
Skin condition □
*(please specify)*_____
Cold sores □
Loss of sensation □
*(describe)*_____
Plantar warts □
Athlete`s foot □

MUSCLE / JOINTS

Neck □
Low back □
Upper back □
Shoulder □
Elbow □
Wrist □
Hip □
Knee □
Ankle □

GYNECOLOGY

Menstrual problems □
Pregnancy □
*Due date*_____
Menopausal problems □
Other concerns □

OTHER

Hemophiliac □
Epilepsy □
Scoliosis □
Chronic fatigue syndrome □
Arthritis OA□ RA □
Fibromyalgia □
Osteoporosis □
Carpal tunnel syndrome □
Fainting/dizziness/loss of consciousness □
Hernia □
Cancer _____ □
Mental Illness □
*(specify)*_____

Overall, how would you rate your general health? _____
Is there family history of any conditions described above? (*list*)_____
Additional medical information? (*describe)*_____

This is to confirm and acknowledge that the above-mentioned information is correct and accurate to my knowledge and that I give my consent for treatment by a Registered Massage Therapist at the Westney Heights Chiropractic Centre. I also acknowledge the policy that appointments cancelled with less than 24 hours' notice or any missed appointments will be subject to a charge of 100% of the appointment fee.

Signature: _____ Date: _____

For office use:
Updated on: _____ _____ _____