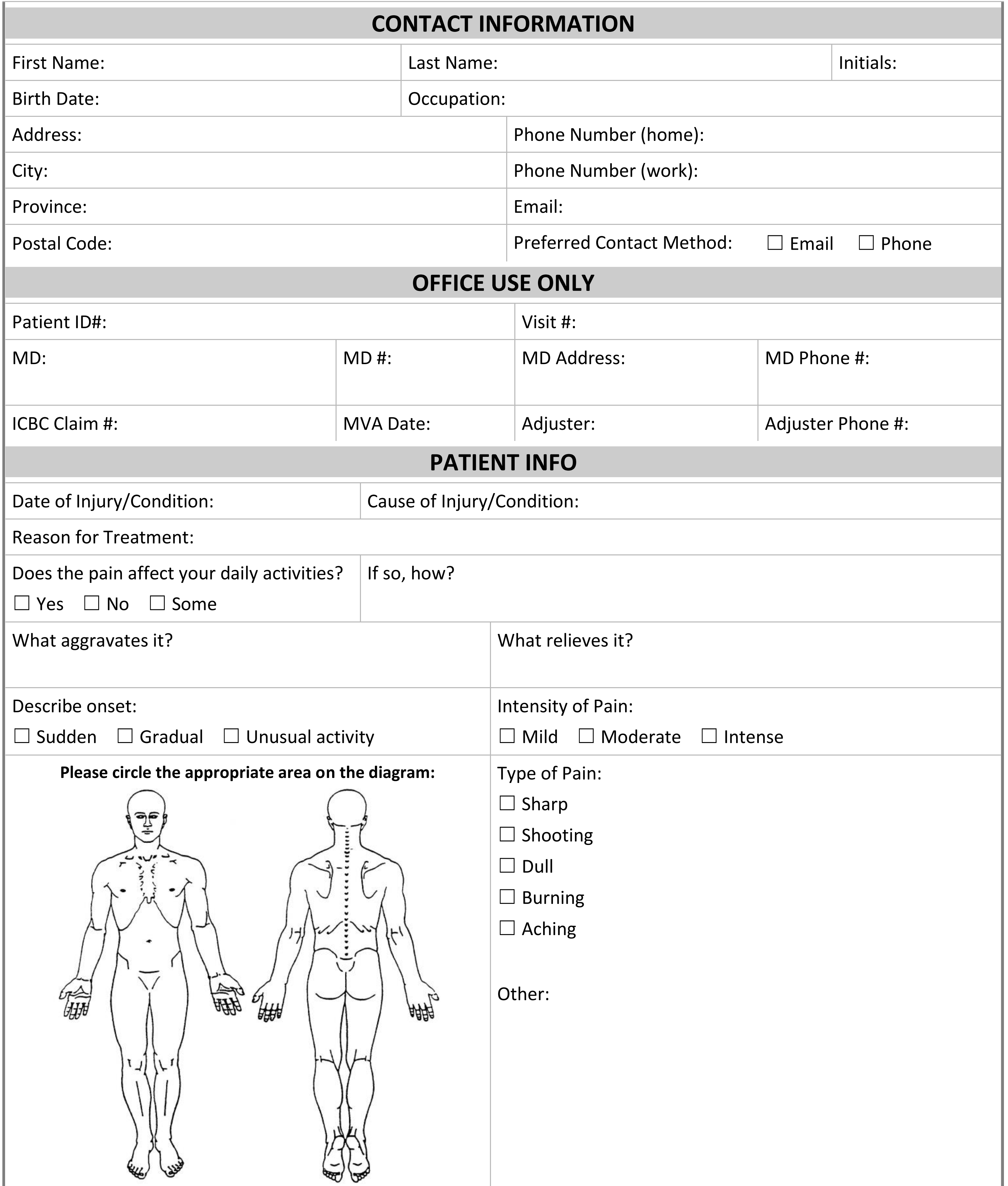
Active Massage Therapy Clinic

CASE HISTORY FORM



CONTACT INFORMATION

First Name:	Last Name:	Initials:
Birth Date:	Occupation:	

Address:	Phone Number (home):
City:	Phone Number (work):
Province:	Email:
Postal Code:	Preferred Contact Method: ☐ Email ☐ Phone

OFFICE USE ONLY

Patient ID#:		Visit #:	
MD:	MD #:	MD Address:	MD Phone #:
ICBC Claim #:	MVA Date:	Adjuster:	Adjuster Phone #:

PATIENT INFO

Date of Injury/Condition:	Cause of Injury/Condition:
Reason for Treatment:	
Does the pain affect your daily activities? ☐ Yes ☐ No ☐ Some	If so, how?

What aggravates it?	What relieves it?
Describe onset: ☐ Sudden ☐ Gradual ☐ Unusual activity	Intensity of Pain: ☐ Mild ☐ Moderate ☐ Intense
Please circle the appropriate area on the diagram:	Type of Pain: ☐ Sharp ☐ Shooting ☐ Dull ☐ Burning ☐ Aching Other:

GENERAL MEDICAL HISTORY

Are you currently seeing another practitioner? ☐ Yes ☐ No	If so, select from the following: ☐ MD ☐ RMT (Massage) ☐ Physio ☐ Chiro Other:

Current medications and why?

Medical history check-list:

☐ Heart Condition	☐ Stroke	☐ Diabetes
☐ Fainting	☐ High/Low Blood Pressure	☐ Circulatory Problems
☐ Headaches	☐ Head Injury	☐ Skin Problems
☐ Cancer	☐ Kidney Problems	☐ Allergies
☐ Insomnia	☐ Respiratory Condition	☐ Jaw Pain
☐ Fibromyalgia	☐ Chronic Fatigue Syndrome	☐ HIV
☐ Fractures	☐ Bone Dislocation	☐ Spinal Injury
☐ Sprains/Strains	☐ Arthritis	☐ Rheumatism
☐ Osteoporosis	☐ Contagious Diseases	☐ Digestive Problems
☐ Pregnancy	☐ Seizures	☐ Current Infections

Any other past illness, injury, or surgery? ☐ Yes ☐ No	If yes, explain:

Where did you hear/learn about our clinic?

Your time is valuable, so is ours. If you can't keep your appointment, please notify us **24 HOURS** in advance. Otherwise, we must charge a cancellation fee.

Patient/Guardian signature

Date