City Core Therapeutic Massage & Neuromuscular Centre

Confidential Case History

NAME: DATE:

ADDRESS: HOME PHONE:

CITY : MOBILE NO.

POSTAL CODE: EMAIL

OCCUPATION:

- PRESENT SYMPTON: What is your major complaint ?

- MINOR COMPLAINT: Other areas of pain and concern ?

When did you notice your major complaint?

Was it sudden onset ( ) gradual onset ( )

What brought it on?

What activities aggravate the condition ?

Is this condition getting progressively worse ? Yes ( ) No( ) Constant ( ) or comes and goes ( )

Is this condition interfering with your : Work ( ) Sleep ( ) Daily Routine ( ) Social Activities ( ) Exercise ( )

What have you done to get relief ? (Over the counter Meds,Prescription Meds,Physio,Chiro,Heat,Cold)

Have you had a similar problem in the before ? If yes, when?

Briefly list and date any previous injuries (childhood,sports,MVA,sprains,fractures,surgery,etc) and or illnesses.

Please list all medications you are presently taking.

Do you exercise regularly ? If yes,list type of exercise(s) and frequency done

(Over)

Please check ( ) if you had any of the following conditions:
Please underline any currently affecting you

( ) Headache	( ) shortness of Breath	( ) Backache : low/mid/upper
( ) Arthritis	( ) Chest Pains	( ) Disc Problems
( ) Numbness,Tingling	( ) Fatigue	( ) HIV pos. / Aids
( ) High Blood Pressure	( ) Dizziness	( )Respiratory disease
( ) Heart Disease	( ) Diabetes	( ) Stomach Problems
( ) Varicose Veins	( ) Muscle Spasms	( ) Cold Hands or Feet
( ) Atherosclerosis	( ) Painful Joints	( ) Epilepsy
( ) Osteoporosis	( ) Swollen Joints	( ) Insomnia
( ) Surgical Implants	( ) Bruise easily	( ) Pregnancy
( ) Hepatitis, type:	( ) Skin Infections	( )Depression
( ) Cancer	( ) Allergies:	( ) Other

PREVIOUS MASSAGE THERAPY VISITS THIS YEAR No._____

HOW DID YOU HEAR ABOUT US ? MD ( ) FRIEND /RELATIVE ( ) SOCIAL MEDIA ( ) MY OWN WEBSITE ( )

P.H.N. SURNAME : NAME :

Birth Date : M./ D./ YR./

Referring Dr. Phone No.

Physio/Chiro Phone No.

ICBC/WCB Claim No.

ICBC/WCB Adjuster Phone No.

Client Responsibilities

24 hrs notice is required for changing or cancelling appointments , otherwise the full appointment fee will be charged. Missed appointments are subject to full appointment fee

In the event of non-payment by an insuring agency (MSP,ICBC) the client is responsible for complete cost of their treatment , according to the current fee schedule.

SIGNATURE **Date : M./ D./ YR,/**