Sumas Mtn. CHIROPRACTIC & WELLNESS CLINIC
"Health care for the active family"

CONFIDENTIAL PATIENT HISTORY FORM

Name _____ **Birthdate** _____
(month/day/year)

Address _____ **Family Doctor** _____

_____ Phone _____

Postal Code _____ **Referring Professional** _____

Phone (home) _____ Phone _____

(work) _____

(cell) _____ Text Appointment Reminder? **Y/N** If yes, cell provider: _____

Email _____ Email Appointment Reminder? **Y/N**

Occupation _____

ICBC or WCB? ❑ No ❑ Yes
(if yes, please ask for extra forms)

How did you hear about Registered Massage Therapy? _____

How did you hear about our clinic? _____

Please indicate if you believe if any of the following apply to you? (P=past C=current) Circle if necessary.

__ Heart Attack
__ High / Low Blood Pressure
__ Stroke or Aneurysm
__ Pace Maker
__ Other Heart Condition
__ Varicose Veins
__ Bruise easily
__ Other Circulatory Condition

__ Diabetes
__ Kidney Disease
__ Other Urinary Condition

__ Headaches / Migraines
__ Dizziness / Fainting
__ Nausea
__ Spinal Injury
__ Head Injury
__ Epilepsy / other seizures
__ Other Neurological Conditions

__ Asthma
__ Chronic Sinusitis
__ Other Respiratory Condition

__ Irritable Bowel / Colitis
__ Digestive Condition
__ Skin Condition

__ Joint Dislocation
__ Bone Fracture
__ Arthritis
__ Osteoporosis
__ Rods / Pins / Plates / Shunts
__ Implants _____
__ Transplant _____
__ Corrective Lenses / Contacts

__ Cancer _____
__ Hepatitis
__ HIV
__ Other Contagious Condition
_____

Are you pregnant? ❑ Yes ❑ No
Please Comment: _____

Please list any Medications you presently take:

_____

_____

Known Allergies (including medications, foods, seasonal, oils and lotions, etc.)

_____

Do you have any family history of medical conditions? ❑ Yes ❑ No
Please List: _____

Have you ever been hospitalized, had any major accidents, illnesses, or surgeries? ❑ Yes ❑ No
Please Comment: _____

_____

Continued over…

Other therapy / treatment : (past or present, does not have to be related to this visit)

❑ Massage Therapy	Date of last visit	_____	Location	_____
❑ Chiropractor	"	_____	"	_____
❑ Physiotherapy	"	_____	"	_____
❑ Naturopath	"	_____	"	_____
❑ Acupuncture	"	_____	"	_____
❑ Other _____	"	_____	"	_____

List any Activities, Sports, Hobbies
(ie. Jogging, Hockey, Crafts, Computer, etc)

_____
_____
_____

List any **NON-prescription vitamins, minerals or other supplements** you are taking:

_____
_____
_____

Please CIRCLE the answer closest to how you PRESENTLY feel: (1 = poor, 5 = excellent)

Quality of Sleep	1	2	3	4	5
Energy Level	1	2	3	4	5
Eating Habits	1	2	3	4	5
Stress Level	1	2	3	4	5
Exercise Habits	1	2	3	4	5

Hours of sleep per night (approx) _____

Number of meals you regularly eat per day _____

Number of times you exercise per week _____

Smoker	Yes	No	Occasional
Alcohol	Yes	No	Occasional

Current Condition

Please describe your current condition & symptoms:

_____
_____
_____
_____

How long have you had this condition?

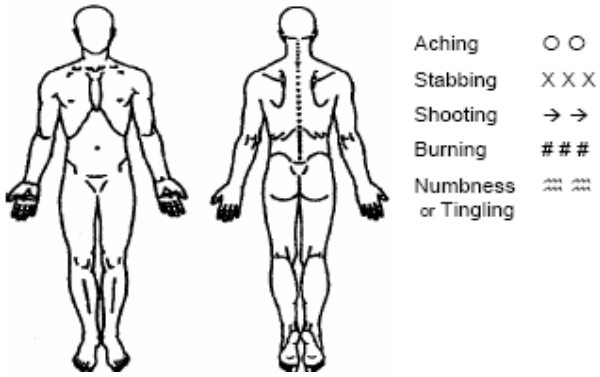
_____

How did it start? _____

What aggravates it? _____

What relieves it? _____

Please indicate on the diagram the nature of your symptoms, using the symbols indicated:



Patient Consent

The Registered Massage Therapists at Sumas Mountain Chiropractic & Wellness Clinic make every effort to ensure your treatment is safe and effective. The approach to treatment may vary depending on your condition(s). At any time before or during the massage treatment, you have the right to ask that the treatment, or portion of, be discontinued. If you have any questions or concerns related to the treatment or techniques used, we encourage you to communicate this to your therapist.

This case history form will be kept as a part of your patient file. All information within your file will be kept confidential and will not be released without your prior consent. You will be required to pay for any treatment related fees which have not been or are not covered by your health insurance or ICBC.

Please sign below to indicate that you have read and understood the above and that the information you provided in this case history form is accurate.

PLEASE NOTE: If you are unable to keep an appointment with the massage therapist, and have failed to give 24 hours notice, a cancellation fee will be charged.

I hereby acknowledge that all of the information herein is correct to the best of my ability:

Signature of Patient:_____ Date:_____
-or parent/guardian if under 19 years