GLENBOURNE CHIROPRACTIC
INSPIRE WELLNESS.

MASSAGE THERAPY Patient Case History
Date: ____________________ **File#** ________________

The information requested will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: ____ Home Phone: ____________________

Address: ____ Cell Phone: ____________________
Street & # Apt # City/Prov Postal Code

Occupation: ______________________ Employer: __________________ Business Phone: ___________________

Date of Birth: ____________________ Health Card #: _______________ Email Address: ____________________

Emergency Contact: __________________ Phone Number(s): _____________ Relationship ________________

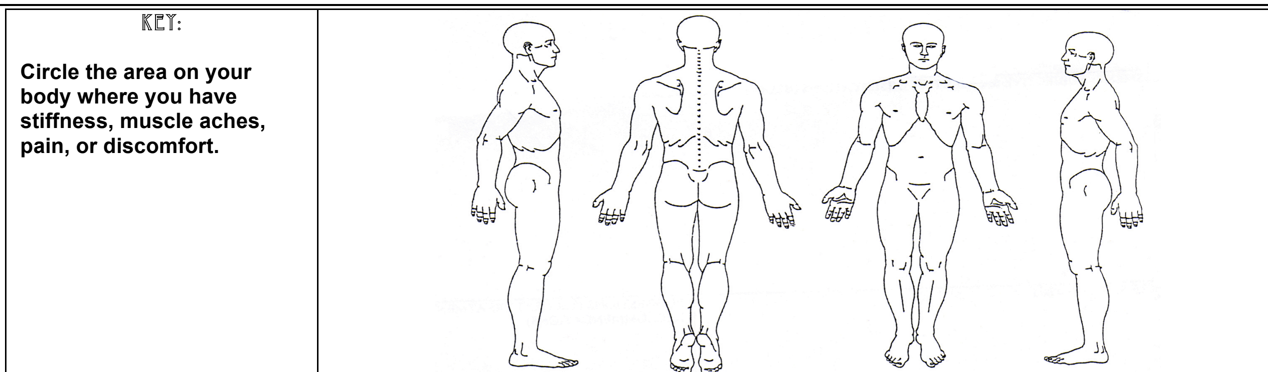
Blue Cross Coverage? If yes, Policy #: __________________________ ID# _______________________

Physician: ______________________ Address: _________________________ Phone: ____________________

Who can we thank for referring you to our clinic?: _____________________ Yellow Pages yes no

WCB claim: yes no Claim#:	Date of Accident:
Motor Vehicle Accident: yes no	Date of Accident:

Major complaint: ____



What makes the condition worse?: ____

What makes the condition better?: ____

Have you had this condition in the past?: yes no If yes, was it resolved?: yes no

Did you have x-rays for this condition? yes no If yes where on the body? ____________

Are you seeing a chiropractor?: yes no Dr. Fox Dr. Peddle Other: ___________________

Stress Level: none slight moderate severe

Physical Activity: none low (1 or 2x per week) moderate (3 – 4x per week) high (5x + per week)

(more on the other side…)

Client Health History Form

Cardiovascular System	Nervous System	Medications
aneurysm high blood pressure/hypertension low blood pressure/hypotension heart disease stroke varicose veins phlebitis bruise easily pacemaker	multiple sclerosis Parkinson's seizures/epilepsy carpal tunnel altered/loss of sensation Specify areas: ______________________________ ______________________________ ______________________________	Please indicate type, what it is for and the times that it is taken: ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________
Digestive Systems	**Skin**	**Respiratory Systems**
ulcers constipation ulcerative colitis Crohn's disease gall stones irritable bowel syndrome (IBS) liver disease Other (specify): ______________________________ ______________________________	plantar warts eczema psoriasis fungal infection (ex. athlete's foot) herpes simplex Other (specify): ______________________________ ______________________________ ______________________________ ______________________________	bronchitis asthma emphysema sinusitis chronic cough breathing problems Specify: ______________________________ ______________________________
Head/Neck	**Other Conditions**	**Muscles and Joints**
history of headaches history of migraines vision problems or loss hearing/ear problems dizziness **Women** menopausal problems painful menstruation pregnant Due date: ______________________________ ______________________________ caesarean section endometriosis Other (specify): ______________________________ ______________________________ ______________________________	hepatitis HIV/AIDS diabetes chronic fatigue syndrome environmental illness allergies Specify: ______________________________ ______________________________ ______________________________ tumours/cysts cancer Specify: ______________________________ ______________________________ ______________________________ Other (specify): ______________________________ ______________________________	fibromyalgia osteoporosis arthritis Specify type and location: __________________________ __________________________ __________________________ pain/stiffness: head neck jaw back Lower Middle Upper arm/hand leg/foot
Other Healthcare	**Surgeries**	**Previous Injuries**
physician/medical doctor chiropractor massage therapist physiotherapist naturopathic doctor nutritionist/dietician Other (specify): ______________________________ ______________________________	Please indicate type, area(s) and date of surgery: ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________	Please indicate area(s), date of injury and a brief description of what happened: ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________

By my signature below, I authorize that all of the information is filled to the best of my knowledge. I understand that all my personal information is confidential and will be treated in accordance with the Personal Information Act. **Please allow 24 hours notice for cancellation of appointments. There will be a $25 fee for any appointments missed without sufficient notice.**

Signature: ______________________________ Date: ______________________________