

CASE HISTORY FORM

Name _____ Telephone Home _____ Work _____
Address (street) _____ (city) _____ (postal code) _____
Email _____ Date of Birth _____ Occupation _____
You were referred by _____ ICBC claim # _____

HEALTH HISTORY: Please check the condition(s) that you experience frequently or are currently experiencing.

Muscles / Joints / Nerves

- tension or migraine headaches
- whiplash/motor vehicle accident
- neck pain/ stiffness/injury
- arm pain/stiffness/tingling
- back pain/stiffness/injury
- hip pain/weakness/tingling
- shoulder pain/stiffness
- hand pain/tingling
- head trauma/concussion
- knee or foot pain
- loss of coordination/dizziness
- sleep or personality changes
- epilepsy/seizures
- tooth/jaw/ear pain
- vision or hearing difficulties
- MS
- degenerative disc disease
- osteo/rheumatoid arthritis
- osteoporosis or bone disease
- spasm/strain or sprain
- tendonitis/fibrositis/bursitis
- fractures pins/wires/plates
- fibromyalgia
- sports/work related injury
- repetitive strain injury
- carpal tunnel syndrome
- chronic fatigue

Skin / Immunity

- skin conditions
- bruise easily
- open sores
- HIV
- allergies/anaphylaxis
- tuberculosis or hepatitis
- cancer

Digestive / Uro-genital

- difficulty digestion
- constipation
- diabetes onset _____
- liver/gall bladder
- are you pregnant
- hip or flank pain
- nausea or vomiting
- rapid weight loss
- diarrhea
- appetite change
- conditions of the colon
- ulcers

Cardiovascular

- heart disease
- stroke
- high blood pressure

Lungs / Respiratory

- asthma or bronchitis
- emphysema

- shortness of breath
- frequent colds/sinus
- chronic cough/smoking

Life Questions

- I exercise regularly
- I feel good about life
- I have good sleeping patterns
- I would like increased energy
- I suffer from too much stress

Please list any surgery:

Please list any predominant family diseases: (eg: heart disease, diabetes)

Please list any medications you are taking _____

Your physician or primary health care provider:

Previous Treatment

Hobbies _____

Why are you here? _____

When/How did this condition begin? _____

What aggravates it? _____ What relieves it? _____

I understand that the information on this form will be confidential; and will be used for no other purpose than the professional therapist's records. **CANCELLATION POLICY:** I understand that if I do not give 24-hour cancellation notice I will be charged in full for a missed appointment.

Signature _____ Date _____

See over.....

