Confidential Case History **Date:** _____

Name: _____ Date of Birth: _____
Address: _____
Town/City: _____ Tel(Home): _____
Postal Code: _____Tel (Cell):_____
Weight: _____Height:_____Tel(Work):_____
E-mail: _____ Occupation:_____
Doctor: _____ Dr. Tel #: _____
Address: _____
How did you hear of us? MD ☐ Newspaper ☐ Yellow Pages ☐ Friend ☐ Other ☐
Have you had massage in the past? ☐ Yes ☐ No
Are you currently seeing: MD ☐ Chiropractor ☐ Physiotherapist ☐
Psychotherapist/Counselor ☐ _____

Health History: Please check applicable boxes

Head/Neck:
☐ headaches – frequency _____
type: _____
☐ vision problems/loss
☐ contact lenses
☐ hearing loss/impairment
☐ fainting
☐ epilepsy
☐ sinus
☐ dizziness
☐ whiplash
date: _____

Respiratory:
☐ chronic cough
☐ shortness of breath
☐ asthma
☐ bronchitis
☐ emphysema

Women:
☐ pregnant
number of children _____
☐ menopause
☐ gynecological conditions

Cardiovascular:
☐ low blood pressure
☐ high blood pressure
☐ poor circulation
☐ heart disease
☐ hypoglycemia
☐ hardening arteries
☐ stroke
☐ hemophilia
☐ varicose veins
☐ chronic congestive heart failure
☐ pacemaker
☐ history of heart attack

Skin conditions:
☐ sensitive skin
☐ rashes/eruptions
☐ herpes
☐ phlebitis
☐ bruise easily
☐ loss of sensation
where?_____
☐ infectious skin conditions

Digestive/Uro-genital:
☐ poor appetite
☐ constipation
☐ liver/gall bladder
☐ kidney/bladder
☐ difficult digestion
☐ diabetes
☐ ulcers

☐ any pins/wires/metal plates?
If so, where? _____

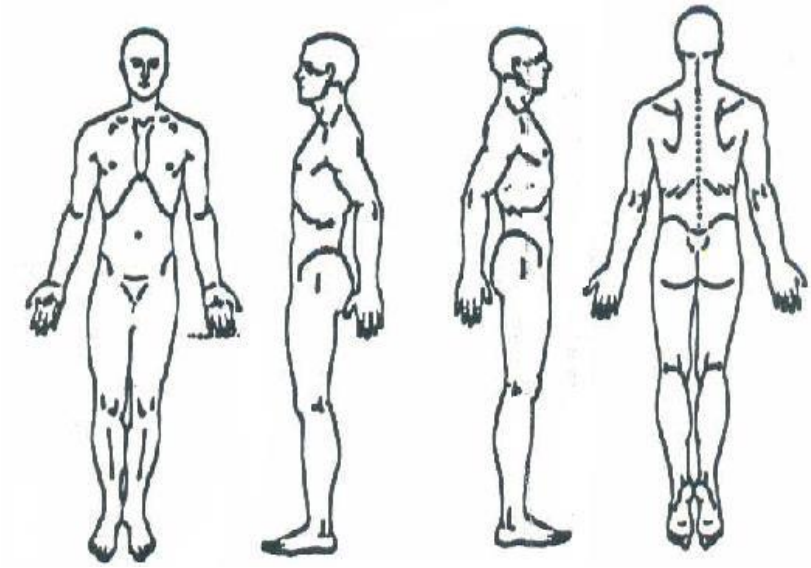
What is your general health status? _____
_____

Other:
☐ arthritis ☐ osteoarthritis ☐ rheumatoid arthritis ☐ osteoporosis
☐ HIV ☐ hepatitis ☐ TB
☐ insomnia ☐ scoliosis ☐ fibromyalgia
☐ allergies (where response = anaphylaxis/skin irritation) – please list:
_____
☐ cancer – type: _____
☐ Other diagnosed diseases/medical conditions: _____
☐ Family History of arthritis
☐ surgeries/accidents – type: _____date: _____
_____ date: _____

Current Medications:
Name: _____ Condition treated: _____
_____ _____
_____ _____
_____ _____

Current Complaint:
Are you seeking therapeutic massage for relaxation only? (Circle one) YES NO
OR for treatment of a specific problem? (Circle one) YES NO
How long have you had this condition/injury? _____

Please identify areas of current symptoms including pain or loss of sensation by indicating on the diagram below:



Check the boxes, which describe the qualities of your pain:

- ❑ Sharp
- ❑ Deep
- ❑ Constant
- ❑ Shooting
- ❑ Superficial
- ❑ Intermittent
- ❑ Burning
- ❑ Poorly localized
- ❑ Brief, transient
- ❑ Aching
- ❑ Dull
- ❑ Throbbing
- ❑ Well localized

Indicate on the scale where you feel your current level of pain lies:

NO PAIN 0____1____2____3____4____5____6____7____8____9____10 ____ WORST PAIN EVER

What increases your pain? _____

What relieves your pain? _____

Consent & Office Policy

- The information on this form is complete and accurate to the best of my knowledge and I will update my therapist of any changes in my health status.
- I understand that the information given on this form is confidential and will be used only for the therapist's clinical records. I consent that all practitioners involved in my healthcare at Access Wellness may have access to the information contained in my clinical files. There will be no release of this information to any other party without written authorization from me. The clinic privacy policy has been made available to me.
- I give my consent for treatment as outlined by the therapist. It is my responsibility to communicate with the therapist. I understand that during the course of treatment I am encouraged and have the right to ask questions about procedure or effects of my treatment. At any time before or during, I can ask the therapist to alter or stop the course of treatment.
- I understand and agree that payment is due at the time of appointment. I will be charged the full treatment fee for any appointment cancelled with less than 24 hours notice. All reminder calls are a courtesy only. I understand that I will be responsible for all missed appointments and will be charged the full fee. These charges will not be covered by my extended healthcare insurance.

Signature: _____ Date: _____

Health Status Update:
Date: