PITT MEADOWS WELLNESS CENTRE

...experience life!

604-465-1624

REGISTERED MASSAGE THERAPY- MEDICAL CASE HISTORY

NAME: ____
(As it appears on your Care Card)

Date of Birth: ______________ (   ) ☐ M ☐ F
Month / Day / Year   *Age*

Address: ____

City: ____________________ Postal Code: ______________

Phone (Res): ______________ Phone (Work): ______________

Occupation: ____

Employer: ____

Date: ____________________

E-mail: ____________________

Care Card #: ______________

Dr. Name: ________________

Referred by: ______________

☐ If this is a current I.C.B.C. claim (accident within the last 8 weeks), please complete the following:

Claim #: ______________________ Date of Accident: ______________________

Adjustor: ______________________ Phone #: ______________________

Lawyer (if applicable): ______________________ Phone #: ______________________

PLEASE INDICATE IF YOU KNOW, OR ARE UNSURE IF ANY OF THE FOLLOWING APPLY TO YOU.

- ☐ Heart Condition
- ☐ Kidney Condition
- ☐ Circulatory Condition
- ☐ Respiratory Condition
- ☐ Hepatitis ☐ Tuberculosis ☐ H.I.V. (+)
- ☐ Infectious / Contagious Condition
- ☐ Neurological Condition
- ☐ Blood Pressure: High or Low
- ☐ Spinal Injury
- ☐ Head Injury
- ☐ Epilepsy / Seizures
- ☐ Headaches: Migraine or Tension
- ☐ Jaw Pain
- ☐ Insomnia
- ☐ Fractures
- ☐ Fainting / Dizziness
- ☐ Nausea
- ☐ Diabetes Class________ Insulin Diet
- ☐ Stroke
- ☐ Cancer
- ☐ Do You Wear Corrective Lenses?
- ☐ Currently Pregnant: Due Date: ______________
- ☐ Skin Conditions: ______________________
- ☐ Other Conditions: ______________________

Please turn page over...

ADDITIONAL INFORMATION

ARE YOU PRESENTLY TAKING ANY MEDICATIONS?
☐ Pain Killers ☐ Muscle Relaxants ☐ Anti-Inflammatories ☐ Cold medications ☐ Other

If Yes, indicate what type of Medication:_______________

ARE YOU CURRENTLY SEEING ANOTHER PRACTITIONER?
☐ Massage Therapist ☐ Physiotherapist ☐ Chiropractor ☐ Other: _______________

HAVE YOU HAD ANY MAJOR ACCIDENTS, ILLNESS OR SURGERY? ☐ YES ☐ NO

If Yes, please explain briefly & give dates: _______________

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Please explain the nature of your present condition. i.e. locations & nature of discomfort, duration, frequency, activities that affect this condition, etc. Describe as accurately as you can your reason for coming here today & indicate the involved areas on the diagram below.

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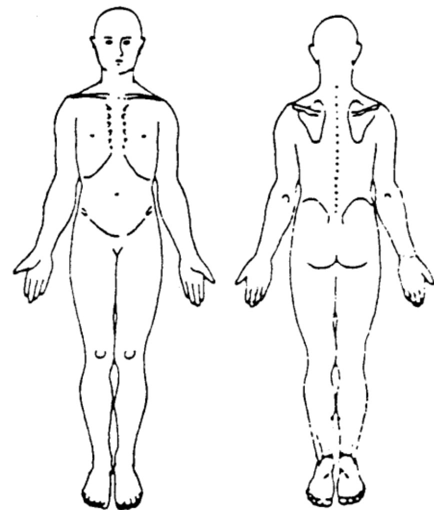

PLEASE NOTE:

Your appointment time is reserved for you. If it is necessary to reschedule an appointment, please allow 24 hours notice, otherwise a charge of $25 per ½ hr (barring any emergency) will be applied.

Signature: _______________ **Date:** _______________

Thank you for taking the time to fill out this case history form. It will greatly assist our therapists in their assessment of your condition & help to create a treatment plan.

Please turn page over…