**CASE HISTORY** **CONFIDENTIAL**

Date: _____

Name: _____ Birthdate: _____ mm/dd/yy

FOR OFFICE USE

File No.:

E-mail Address: _____ Care Card No.: _____

Address: _____ City: _____ Postal Code: _____

Phone No. home: _____ Work: _____ Cell: _____

Medical Doctor's Name: _____ Occupation: _____

Who were you referred by? Friend (name): _____ Other: _____

Hobbies/Recreation: _____

Briefly describe the conditions or reasons are you coming for treatment: _____

_____

_____

How long have the above reasons/conditions existed? _____

Do you regard your conditions to be: ☐ severe ☐ moderate ☐ mild

Please check if you are currently receiving treatment from any of the following:
Medical Doctor ☐ Chiropractor ☐ Naturopath ☐ Physiotherapist ☐ Other: _____

Are you presently involved in an ICBC claim? yes ☐ no ☐ Involved in a WCB claim? yes ☐ no ☐

Please list previous illness/accidents/surgeries that you have had (please note date and type): _____

_____

_____

_____

Please list any **medication** you are currently using, including non-prescription: _____

_____

Please list any **supplements** you are currently taking (vitamins, minerals, amino acids, etc.): _____

_____

What is your goal in seeking treatment for your condition (i.e. total resolution, pain free movement, etc.)? _____

_____

Are you willing to make some changes in your lifestyle, if necessary, to resolve your condition? Yes ☐ No ☐ Explain:

_____

_____

What is your daily **WATER** intake? (not including fruit juice, coffee, tea, soft drinks, alcohol):

☐ 2 Liters or more ☐ 1 Liter ☐ 500 mL ☐ less than 500 mL

Briefly describe your diet (fast food, processed food, natural foods, etc.):_____

_____

_____

Are your bowel movements: ☐ daily ☐ less than daily Do you smoke cigarettes? How many per day?_____

How often do you exercise? ☐ daily ☐ weekly ☐ occasionally ☐ never

On a scale of 1 (low) to 10 (high) what is your daily energy level? _____

On a scale of 1 (low) to 10 (high) where do you want to daily energy level to be? _____

Do you use orthotics in your shoes?_____

***If you are female:*** *Are you pregnant?* _____ *If yes, what is your due date?*_____

*Menstrual cycle:* ☐ *regular* ☐ *irregular* ☐ *painful* ☐ *heavy* ☐ *menopausal* *other*_____

*Do you have children? If so, how many (indicate natural or cesarean delivery):* _____

_____

Please check if you presently have, or have had in the past, any of the following conditions:

| | present | past |
|---|---|---|
| arthritis | | |
| contagious disease | | |
| cancer | | |
| cardiovascular disease | | |
| chronic infection | | |
| diabetes | | |
| digestive ulceration | | |
| osteoporosis | | |
| tuberculosis | | |

| | present | past |
|---|---|---|
| epilepsy | | |
| fibrositis/fibromyalgia | | |
| head or neck trauma | | |
| high blood pressure | | |
| haemophilia | | |
| kidney disease | | |
| rheumatism | | |
| spinal disc injury/disease | | |
| skin conditions | | |

Please check any of the following conditions currently bothering you:

| | slight | moderate | severe |
|---|---|---|---|
| painful muscle tension | | | |
| muscular cramps | | | |
| sore aching joints | | | |
| frequent cracking or popping sounds in joints | | | |
| restricted joint movement | | | |
| ligament sprain | | | |
| muscle strain | | | |
| joint dislocation | | | |
| pain on walking | | | |
| sore feet | | | |
| painful legs | | | |
| low back pain | | | |
| mid-back pain | | | |
| upper back/shoulder pain | | | |
| pain in arms/wrists/hands | | | |
| neck pain | | | |
| headache | | | |
| skin infection | | | |
| psoriasis | | | |
| eczema | | | |

| | slight | moderate | severe |
|---|---|---|---|
| digestive problems | | | |
| nausea | | | |
| abdominal cramps | | | |
| painful bowel movements | | | |
| loss of bowel or bladder control | | | |
| menstrual problems | | | |
| pelvic inflammation | | | |
| urinary infection | | | |
| prostate infection | | | |
| cold or flu | | | |
| allergies | | | |
| asthma | | | |
| bronchitis | | | |
| dizziness or light-headed | | | |
| cold hands/feet | | | |
| excessive sweating | | | |
| varicose veins | | | |
| anxiety | | | |
| feel depressed | | | |
| sudden weakness | | | |

**PATIENT CONSENT**

Randy Savard, BA, RMT will make every effort to ensure that your treatment is safe and effective. The approach to treatment may vary depending upon your condition(s). At any time before or during the massage therapy treatment, you have the right to ask that the treatment, or portion of the treatment, be discontinued.

If you have any questions or concerns related to the treatment or techniques used, we encourage you to communicate these to your therapist.

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 heath insurance or ICBC.

Randy Savard, BA, RMT does not accept WCB claims. You are welcome to pay privately or through your extended medical plan for your treatments.

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.

*NOTE: If you are unable to keep an appointment with the massage therapist, and have failed to give 24 hour notice, a $20 surcharge will be charged to you account. Your B.C. MSP visits, however, will not be affected.*

Signature_____ Date_____ Guardian if under 18 yrs._____