

Central Lonsdale Massage Therapy Clinic

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Medical History

In order to give you the best possible treatment please fill out the following form as complete as possible.

Last Name _____ First _____ Middle _____ Birthdate (M/D/Y) _____

Address _____ Phone (H) _____

City _____ e-mail _____ (W) _____

Postal Code _____ Occupation _____ (C) _____

How did you hear about us? _____

YOUR APPOINTMENT TIME IS RESERVED ESPECIALLY FOR YOU.

If you find it necessary to reschedule an appointment, **24 hours notice** is required or you will be billed for the **full treatment amount. Thank you**

Signature: _____ **Date:** _____

Care Card # _____ Dr.'s Name _____ Phone # _____

ICBC /WCB Claim # _____ Adjuster's Name _____ Phone # _____

Reason for Treatment _____

Injury Date _____ Cause of Injury _____

Describe onset of Condition: Sudden Gradual Unusual Activity

Where are you experiencing pain/discomfort? _____

On a scale of 1-10, 10 being the worst, where do you feel your discomfort is at? _____

What aggravates the pain? _____

What relieves the pain? _____

Does the pain affect your daily activities? Y N If so, how? _____

Is the pain more severe at certain times of the day? If so, when? _____

Is the condition/pain getting progressively: worse better stays the same?

Other symptoms felt: grinding popping dizziness numbness weakness nausea
 vomiting none other _____

Has this condition occurred before? Y N Was it resolved? Y N

Are you taking any medications? Y N What type? Pain killer muscle relaxant
 anti-inflammatory sleep depression laxative other _____

Are you seeing another practitioner? MD RMT Physiotherapist Chiropractor
Other _____

Have you had any motor vehicle accidents, surgeries, or other illnesses?

Medical History: P = past C = current

<p>Skin:</p> <p><input type="checkbox"/> rashes</p> <p><input type="checkbox"/> bruise easily</p> <p><input type="checkbox"/> infectious condition</p> <p><input type="checkbox"/> other</p> <p>Muscle/Joints:</p> <p><input type="checkbox"/> strain</p> <p><input type="checkbox"/> sprain</p> <p><input type="checkbox"/> dislocation</p> <p><input type="checkbox"/> osteoporosis</p> <p><input type="checkbox"/> osteoarthritis</p> <p><input type="checkbox"/> fracture</p> <p>Respiratory:</p> <p><input type="checkbox"/> asthma</p> <p><input type="checkbox"/> bronchitis</p> <p><input type="checkbox"/> emphysema</p> <p><input type="checkbox"/> smoking</p> <p><input type="checkbox"/> difficulty breathing</p> <p><input type="checkbox"/> shortness of breath</p>	<p>Cardiovascular:</p> <p><input type="checkbox"/> high/low blood pressure</p> <p><input type="checkbox"/> heart attack</p> <p><input type="checkbox"/> heart disease</p> <p><input type="checkbox"/> angina</p> <p><input type="checkbox"/> stroke</p> <p><input type="checkbox"/> cerebrovascular accident</p> <p><input type="checkbox"/> pacemaker</p> <p><input type="checkbox"/> varicose veins</p> <p><input type="checkbox"/> phlebitis</p> <p><input type="checkbox"/> poor circulation</p> <p>Head/Neck:</p> <p><input type="checkbox"/> headaches</p> <p><input type="checkbox"/> visual impairment</p> <p><input type="checkbox"/> hearing impairment</p> <p><input type="checkbox"/> speech impairment</p> <p><input type="checkbox"/> jaw pain</p> <p><input type="checkbox"/> sinus problems</p> <p>Infectious Conditions:</p> <p><input type="checkbox"/> HIV</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> TB</p>	<p>Gastrointestinal Conditions:</p> <p><input type="checkbox"/> constipation</p> <p><input type="checkbox"/> diarrhea</p> <p><input type="checkbox"/> irritable bowel</p> <p><input type="checkbox"/> hiatus hernia</p> <p><input type="checkbox"/> ulcers</p> <p><input type="checkbox"/> gastric reflux</p> <p>Other Conditions:</p> <p><input type="checkbox"/> allergies</p> <p><input type="checkbox"/> cancer</p> <p><input type="checkbox"/> diabetes</p> <p><input type="checkbox"/> fainting</p> <p><input type="checkbox"/> fever</p> <p><input type="checkbox"/> insomnia</p> <p><input type="checkbox"/> numbness/tingling</p> <p><input type="checkbox"/> seizures</p> <p><input type="checkbox"/> stress</p> <p><input type="checkbox"/> implants</p> <p><input type="checkbox"/> orthotics</p> <p><input type="checkbox"/> contact lenses</p> <p><input type="checkbox"/> steel pins</p> <p><input type="checkbox"/> other _____</p>
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Please indicate areas of pain:

