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

Skin:
__ rashes
__ bruise easily
__ infectious condition
__ other

Muscle/Joints:
__ strain
__ sprain
__ dislocation
__ osteoporosis
__ osteoarthritis
__ fracture

Respiratory:
__ asthma
__ bronchitis
__ emphysema
__ smoking
__ difficulty breathing
__ shortness of breath

Cardiovascular:
__ high/low blood pressure
__ heart attack
__ heart disease
__ angina
__ stroke
__ cerebrovascular accident
__ pacemaker
__ varicose veins
__ phlebitis
__ poor circulation

Head/Neck:
__ headaches
__ visual impairment
__ hearing impairment
__ speech impairment
__ jaw pain
__ sinus problems

Infectious Conditions:
__ HIV
__ Hepatitis
__ TB

Gastrointestinal Conditions:
__ constipation
__ diarrhea
__ irritable bowel
__ hiatus hernia
__ ulcers
__ gastric reflux

Other Conditions:
__ allergies
__ cancer
__ diabetes
__ fainting
__ fever
__ insomnia
__ numbness/tingling
__ seizures
__ stress
__ implants
__ orthotics
__ contact lenses
__ steel pins
__ other _____

Please indicate areas of pain: