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: