254 Main Street North, Markham, Ontario. L3P 1Y7. T: 905-294-0454 F: 905-294-0480 E: info@activehealthcentre.com

CONFIDENTIAL PATIENT CASE HISTORY FORM

PERSONAL CONTACT INFORMATION

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: _____ Date: _____
Address: _____ Date of Birth _____/_____/_____
_____ Home Telephone Number: _____
_____ Work Telephone Number: _____
_____ Cell Phone Number: _____
_____ Email Address: _____
Occupation: _____ Who referred you? _____
Primary Complaint: _____ Address: _____

HEALTH HISTORY

Please indicate conditions you are experiencing, or have experienced. Check all the conditions that are applicable to you.
What is your general Health Status?_____

Musculo-Skeletal
- ☐ headaches and/or trauma
- ☐ jaw pain/TMJ
- ☐ neck and/or shoulder
- ☐ arm pain Right and/or Left
- ☐ upper mid back
- ☐ low back/hip
- ☐ leg pain Right and/or Left
- ☐ knee pain Right and/or Left
- ☐ tendonitis, bursitis
- ☐ sprains, strains
- ☐ other

Pathologies
- ☐ Liver
- ☐ Kidney
- ☐ Bladder
- ☐ Diabetes
- ☐ Cancer
- ☐ Epilepsy
- ☐ Other

Cardiovascular
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ heart disease
- ☐ varicosities
- ☐ breathing difficulties
- ☐ chronic cough
- ☐ sinus problems
- ☐ allergies
- ☐ other

Nervous System
- ☐ Chronic pain
- ☐ Numbness, tingling
- ☐ Fatigue
- ☐ Insomnia
- ☐ Other

Digestive
- ☐ Constipation
- ☐ Irritable bowel syndrome

Other

Skin
- ☐ Allergies
- ☐ Infections
- ☐ Rashes
- ☐ Wounds, scars
- ☐ Bruise easily
- ☐ Other

Infections
- ☐ Herpes
- ☐ Hepatitis
- ☐ Plantar warts
- ☐ TB
- ☐ HIV, AIDS
- ☐ Other

Women
- ☐ Menstrual problems
- ☐ Gynaecological surgeries
- ☐ Pregnancy due date_____
- ☐ other

Current medications: _____ What condition does it treat? _____
Primary Care Physician: _____ Address: _____
Surgery: _____ Injury: _____
Date: _____ Date: _____
Nature: _____ Nature: _____
Present involvement in Other Health Care? If yes, please specify: _____
_____
Of Special Note: Please indicate the presence of internal pins, wires, artificial joints, special equipment: _____
_____

ACTIVE HEALTH CENTRE

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NATURE OF COMPLAINT

Please indicate the level of pain/discomfort that you are experiencing with your condition.

Can you describe the pain/discomfort? _____

What is the area of complaint? _____

How long have you had this condition? _____

Is it worse or staying the same? _____

Is this condition interfering with: (please circle) Work Sleep Daily Routine Activities

Please Specify: _____

Have you seen any other Health Professional regarding this problem? If yes, who? _____

_____

What was the target treatment plan? _____

Was it successful? Did it bring you any relief? _____

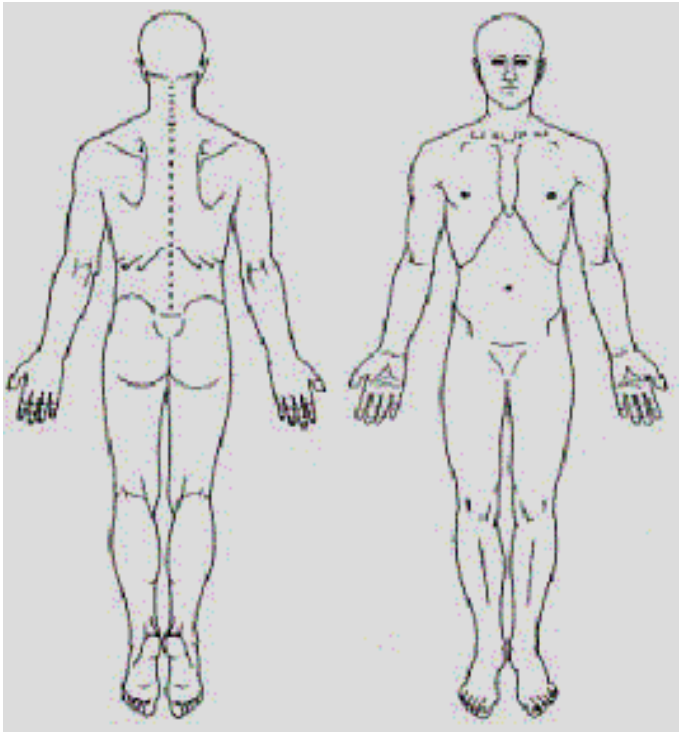
From a pain scale of one to ten, ten being the worst pain, how uncomfortable do you feel? _____

Does the pain/discomfort radiate? If yes, where to? _____

Is there anything that will relieve the pain? For example, hot or cold compresses. _____

DESCRIPTION

Please indicate the area of discomfort with an "X" and briefly describe your condition as best as you can in the space below.



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Please note that a 24-hour cancellation notice is required, otherwise a $35.00 (thirty-five dollars) fee will be charged.

I have state all medical conditions and will update my therapist of any changes in my health status. I have the right to stop, change or request modification for my treatment within the scope of practice of the therapist, and consent to be treated for therapeutic massage.

Name: _____ Date: _____