



Remedial Wellness Centre

Confidential Case History Form

Date: _____

Name: _____ MALE FEMALE

Date of Birth: _____ (dd/mm/yyyy) Occupation: _____

Address: _____ City: _____ Prov: _____

Postal Code: _____ Phone: _____ Cell Phone: _____

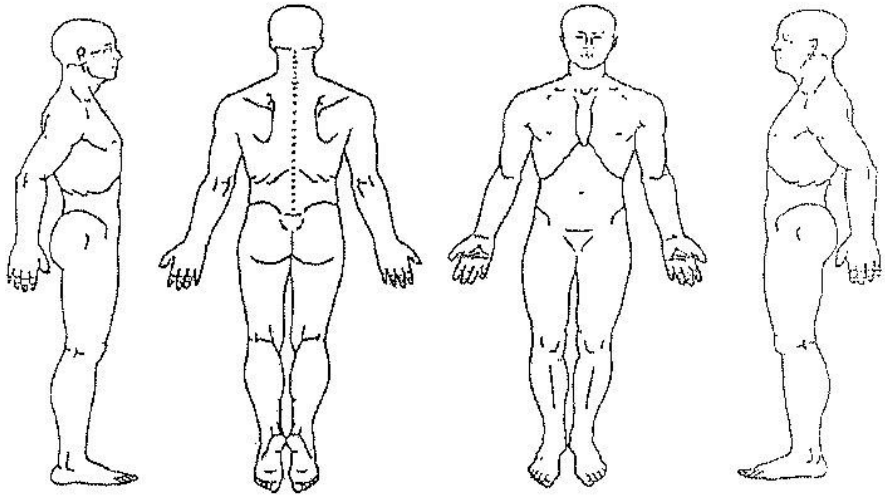
Email: _____

How did you hear about us? _____

Please indicate for the therapist the location of the condition for which you are seeking treatment:

Quality of Symptoms:

X	Sharp/Shooting
#	Dull/Aching
*	Pinching
~~~	Numbness/Tingling
*→	Radiating
(please circle)	Weakness
///	Tightness/Stiffness
^^^	Burning
Δ	Throbbing
□	Pulling



Aggravated by: _____

Relieved by: _____

**Quality of Pain:** Please indicate your level of pain, 1 being no pain and 10 being the worst pain you have ever experienced.

1      2      3      4      5      6      7      8      9      10

**General Assessment**

Please describe your overall sense of wellness using the following areas:

Energy level: _____

Appetite, thirst and taste: _____

Bowel movement & urination: _____

Sleep: _____

Please circle on the following scales the extent to which you are currently satisfied with the following: (5 represents total satisfaction; 1 represents little or no satisfaction).

Physical Health & Fitness	1	2	3	4	5
Mental and Emotional Happiness	1	2	3	4	5
Energy Level	1	2	3	4	5
Diet	1	2	3	4	5
Ability to Relax	1	2	3	4	5

**Please indicate any conditions or pain you are experiencing or have experienced:**

**C = Current; P = Past**

**Cardiovascular**

- C P
- High Blood Pressure
  - Low Blood Pressure
  - Congestive heart failure
  - Heart Attack/TIA
  - Phlebitis/Varicose veins
  - Stroke/CVA
  - Pacemaker or similar device
  - Heart Disease
  - Dizziness/Vertigo
  - Seizures
  - Clotting Disorder/Hemophilia
  - Blood Clots
  - Edema

**Head, Jaw & Face**

- C P
- History of headaches
  - Migraines
  - Vision problems
  - Vision loss
  - Ear problems
  - Hearing loss
  - TMJ

**Muscle & Joint**

- C P
- Neck
  - Low-Back
  - Mid-Back
  - Shoulders
  - Elbow
  - Wrist/Hand
  - Hip
  - Knee
  - Ankle/Foot
  - Spine

**Women's Health**

- Are you pregnant?
  - YES     NO
- If yes, due date? _____
- Have you had a c-section?
  - YES     NO
- Have you had a hysterectomy?
  - YES     NO
- Previous pregnancy complications: _____
- Menopausal/menstrual problems: _____
- Gynecological conditions: _____
- Date of last day of last menstrual cycle: _____

**Respiratory**

- C P
- Asthma
  - Bronchitis
  - Emphysema
  - Chronic Cough
  - Shortness of breath

**Systemic Conditions**

- C P
- Diabetes
  - Onset: _____
  - Type: _____
  - HIV/AIDS
  - Hepatitis
  - Arthritis
  - Fibromyalgia
  - Chronic fatigue
  - Polio
  - Osteoporosis
  - Epilepsy
  - Restless Leg Syndrome
  - SLE/Lupus
  - Rheumatoid Arthritis
  - Severe Burns
  - Multiple Sclerosis
  - Scleroderma
  - Dermatomyositis

- Age of 1st menstruation: _____
- Menstrual period (# of days of flow) _____ OR Irregular _____.
- Menstrual cycle (# of days from day 1 to day 1) _____ OR Irregular _____.
- Associated menstrual symptoms:

**Pregnancies:**

- Number of pregnancies: _____
- Number of abortions: _____
- Number of miscarriages or stillbirths: _____
- Number of live births: _____

**Digestive**

- C P
- Constipation
  - Crohn's Disease
  - Colitis
  - Irritable Bowel Syndrome
  - Ulcers

**Skin Conditions**

- C P
- Eczema
  - Psoriasis
  - Rash
  - Warts
  - Open Sores

**Other**

- C P
- Loss of sensation
  - If so, where? _____
  - Allergies
  - To what? _____
  - Cancer
  - Type: _____
  - Location: _____
  - Treatment Required: _____
  - Date of Remission: _____
- Y N                      Y=Yes; N = No**
- White coat syndrome (anxiety when seeing staff in a white lab coat)

**Men's Health**

- C P
- Enlarged Prostate
  - Erectile Dysfunction
  - Peyronie's Disease
  - Libido Issues
  - Other: _____
  - Have you had a prostatectomy?
    - YES     NO
  - If yes, date? _____

Do you have any medical or skin conditions not listed above?  YES  NO

*If yes, please explain:*

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Do you have any internal wires, artificial joints, pacemakers or special equipment that we should be aware of?  YES  NO

*If yes, please explain:*

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Have you seen any other health care professional(s) for this condition?  YES  NO

*If so, whom?*

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Briefly list any surgeries you have undergone, for what and when:

Date	Procedure	Comments

Are you presently taking any steroids, supplements or prescribed medications?  YES  NO

*If yes, please list the medication(s) and the condition(s) for which it is being used if known. This also includes hormonal replacements, birth control pills and antibiotics.*

Medication Name	Condition Treated

### **Emotional & Mental Activity Profile**

*Are your emotions frequently dominated by any particular feelings, or have you recently had sudden changes in feelings or emotions?*

<input type="checkbox"/> Easily excited/over-excitement, giddiness <input type="checkbox"/> Laughing or crying without reason <input type="checkbox"/> Sadness, grief or melancholy <input type="checkbox"/> Depression <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Anxiety <input type="checkbox"/> Fear <input type="checkbox"/> Fright (easily started or frightened) <input type="checkbox"/> Over-thinking	<input type="checkbox"/> Worry <input type="checkbox"/> Frequent sighing <input type="checkbox"/> Easily or frequently frustrated <input type="checkbox"/> Irritability or easily annoyed <input type="checkbox"/> Anger <input type="checkbox"/> Rage <input type="checkbox"/> Indecision, or difficulty making decisions <input type="checkbox"/> Other: _____ _____
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**Informed Consent to Assess and Treat**

I understand that in order to determine appropriate treatment for the condition for which I have, that I will have to undergo a physical examination which may involve questioning, observing, hands-on assessment of the area(s) of the body and disrobing to some degree as deemed appropriate at the time of examination. I also understand that consent to be assessed and treated may be withdrawn at any time. I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history and disclosed all of those medical conditions affecting me. It is my responsibility to keep the therapist updated on my medical history. I wish to rely on the practitioner to exercise judgment during the course of the procedure which (s)he feels at the time, based upon the facts then known, is in my best interest. The practitioner has responded to all my requests for further information about the services proposed.

I have read the above consent and have been given the opportunity to ask questions about its content, and by signing below, I agree to the named procedures. I intend this consent to cover the entire course of treatment for my present and for any future conditions for which I may seek treatment. I understand that my consent is required prior to releasing my records to another practitioner, insurance company or any other agency or person except where required by law. The information I have provided is true and complete to the best of my knowledge.

**Cancellation Policy:** Please be advised that there is a 12 hour missed/cancelled appointment policy in effect for all services at Remedial Wellness Centre. Late cancellations (within 12 hours) and missed appointments will be charged 50% of the appointment fee. The same applies if the therapist misses an appointment with a client; (the client's next appointment will be 50% of the full fee).

**Consent to Physical Therapy**

I recognize and approve that I will be receiving treatment which may involve the use of electro physical agents (including ESWT), thermal or mechanical modalities, hands-on muscular or joint therapy, possible acupuncture as well as instruction in various exercises.

I declare that I am at least 18 years old and herby give consent to treatment.

If under 18: I declare that I am this patient's parent or legal guardian. I do herby give consent to treatment.

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Signature of Client, Parent or Legal Guardian

Date

**Consent to Massage Therapy**

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the Massage Therapy Association. I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations, modalities and techniques, which may be recommended by my therapist.

I declare that I am at least 18 years old and herby give consent to treatment.

If under 18: I declare that I am this patient's parent or legal guardian. I do herby give consent to treatment.

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Signature of Client, Parent or Legal Guardian

Date

**Consent to Acupuncture**

I do hereby give my voluntary informed consent for the administration to me of acupuncture treatment and other relevant traditional Chinese medical (TCM) therapies. I declare that I have received information about the nature and course of TCM treatment, benefits, risks, and potential discomfort.

I declare that I am at least 18 years old and herby give consent to treatment.

If under 18: I declare that I am this patient's parent or legal guardian. I do herby give consent to treatment.

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Signature of Client, Parent or Legal Guardian

Date