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: _____

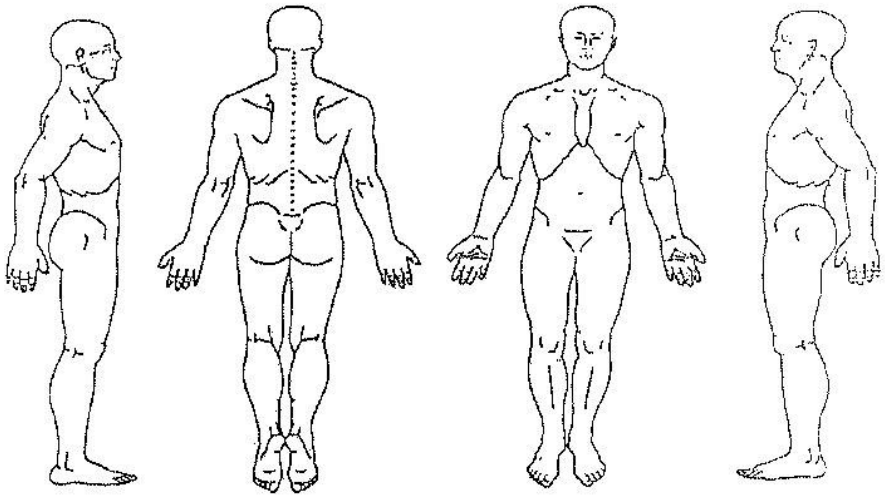
Email: _____

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

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

Respiratory

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

Digestive

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

Skin Conditions

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

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

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

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)

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:
_____

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:

_____

Do you have any internal wires, artificial joints, pacemakers or special equipment that we should be aware of? □ YES □ NO
If yes, please explain:

_____

Have you seen any other health care professional(s) for this condition? □ YES □ NO
If so, whom?

_____

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**

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.

_____

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.

_____

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.

_____

Signature of Client, Parent or Legal Guardian Date