Marlene Henderson RMT

New Patient Information & Clinical Record

Name:		Date:
Address:	City:	Postal Code:
Phone: (Home)	(Cell)	(Work)
Email Address:		
Date of Birth:	Care Card Number:	
Occupation:	ICBC?	Claim #:
Family Doctor:	Office phone #:	
Remind me by: (circle) Text Phone Email	If text, who is your cell carrier?	

Please indicate if any of the following apply to you:

	Present	Past		Present	Past
Heart Attack			Asthma		
High/Low Blood Pressure			Chronic Sinusitis		
Stroke or Aneurysm			Other Respiratory Condition		
Pace Maker			Irritable Bowel/Colitis		
Other Heart Condition			Digestive Condition		
Varicose Veins			Skin Condition		
Bruise Easily			Joint Dislocation		
Other Circulatory Condition			Bone Fracture		
Diabetes			Arthritis		
Kidney Disease			Osteoporosis		
Other Urinary Condition			Rods/Pins/Plates/Shunts		
Headaches/Migraines			Implants		
Dizziness/ Fainting			Transplant		
Nausea			Corrective Lenses/Contacts		
Spinal Injury			Cancer		
Head Injury			Hepatitis		
Epilepsy			HIV		
Other Neurological Conditions			Other Contagious Condition		

Are you pregnant? _____ If yes, due date? _____

Medications you currently take:

_____

_____

Known Allergies:

_____

_____

_____

Do you have a family history of medical conditions?

_____

_____

Have you ever been hospitalized, had any major accidents, illnesses, or surgeries? Yes ☐ No ☐

_____

_____

Other Therapy/Treatment (past or present, does not have to be related to this visit)

☐ Massage Therapy	Last visit: _____	Location: _____
☐ Chiropractor	Last visit: _____	Location: _____
☐ Physiotherapy	Last visit: _____	Location: _____
☐ Naturopath	Last visit: _____	Location: _____
☐ Acupuncture	Last visit: _____	Location: _____
☐ Other _____	Last visit: _____	Location: _____

List any Activities, Sports, Hobbies

_____

_____

_____

List any **NON-Prescription** vitamins, minerals, or other:

_____

_____

_____

Please CIRCLE the answer closest to how you PRESENTLY feel: (1=poor, 5=excellent)

Quality of Sleep _____ Hours of sleep per night (approx.) _____

Energy Level _____ Number of meals you regularly eat per day _____

Eating Habits _____ Number of times you exercise per week _____

Stress Level _____ Smoker yes no occasional

Exercise Habits _____ Alcohol yes no occasional

Current Condition

Please describe your current condition and symptoms:_____

_____

_____

_____

How long have you had this condition?_____

How did it start? _____

_____

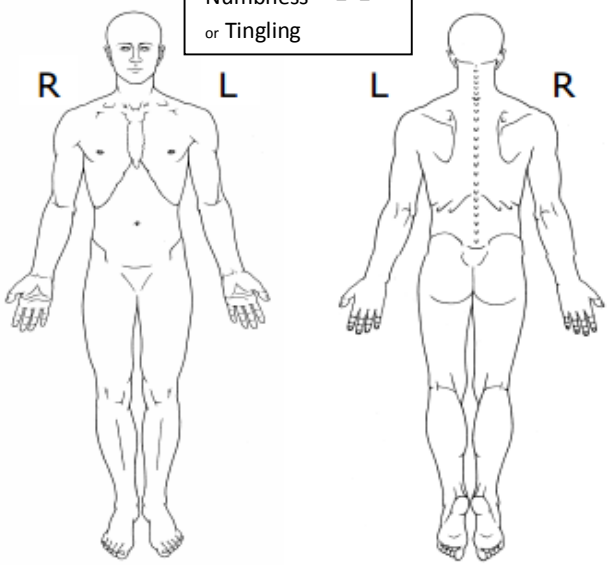
What aggravates it? _____

_____

What relieves it? _____

Please indicate on the diagram the mature of your symptoms, using the symbols indicated:

Aching	O O
Stabbing	X X X
Shooting	-> ->
Burning	# # #
Numbness or Tingling	= =



Marlene Henderson, RMT

Patient Consent

The Registered Massage Therapists at Cascadia Chiropractic make every effort to ensure your treatment is safe and effective. The approach to treatment may vary depending on your condition(s). At any time before or during the treatment you have the right to ask that the treatment, or portion of the treatment, be discontinued. If you have any questions or concerns related to the treatment or techniques used we encourage you to communicate these to Marlene.

This case history form will be kept as a part of your patient file. All information within your file will be kept confidential and will not be released without you prior consent.

You will be required to pay for any treatment related fees which have not been or are not covered by your health insurance or ICBC.

PLEASE NOTE: Your appointment time has been reserved for you. In courtesy of your massage therapist & fellow patients, we ask that you provide us with 24hrs notice or cancellation or a cancellation fee (full amount of the missed visit) will be charged.

Please sign below to indicate that you have read and understood the above and that the information you provided in this case history form is accurate.

Signature _____ Date _____