SAFE, SMART, EFFECTIVE HEALTH CARE

NAME: _____

CONFIDENTIAL CASE HISTORY FORM

Today's Date: _____

Address: _____

_____

Phone # (H): _____

(C): _____

(W): _____

Occupation: _____

Date of Birth: _____

Referring Doctor: _____

Doctor's Phone #: _____

Care Card #: _____

ICBC/WCB Claim #: _____

Date of Accident: _____

Adjuster's Name: _____

Adjuster's Phone #: _____

How did you hear about our clinic: _____

What condition or area would you like treated? _____

Was the onset of pain: ___ Sudden ___ Gradual ___ From an injury? If so, what is the cause of injury? _____

How long ago did the symptoms begin? _____ Is pain worse in: ___ Morning ___ afternoon ___ evening ___ constant?

Has this condition occured before? ___ Y ___ N Resolved ___ Y ___ N Are you taking any medications? ___ No ___ Yes

Please Specify: _____

Are you seeing another practitioner? ___ RMT ___ Physiotherapist ___ Chiropractor ___ Other _____

Have you had a major accident, illness, or surgery? ___ No ___ Yes Please describe _____

_____

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOU:

___ Headaches	___ Neck/Backaches	___ Heart Condition	___ Plate or Pins
___ Dizziness	___ Arthritis	___ Loss of Skin Sensation	___ Allergies
___ Loss of Sleep	___ Abdominal Problems	___ Skin Disorders	___ Cancer
___ Numbness	___ Acute Inflamed Areas	___ High/Low Blood Pressure	___ Respiratory
___ Nausea	___Varicose veins	___ Bruise Easily	___ Diabetes

___ Other (please specify) _____

Fee Policy: The patient or guardian is always responsible for treatment fees.

Cancellation Policy: In consideration of your fellow patients and your therapist, a minimum of 24 HOURS NOTICE is required to change or cancell an appointment. Appointments missed or cancelled on less than 24 HOURS NOTICE are subject to a **"no Show"** fee, payable **before** your next treatment.

Privacy Statement: By my signature below, I authorize the clinic and its associated RMTs to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated RMTs to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

By my signature I confirm that I have read the foregoing and agree to the terms set out and give my consent to treatment.

Signature: _____ **Date:** _____

Guardian (if under 18) _____

Name: _____

Date: _____