

The Brooklin Natural Health Centre

2 Princess St. Brooklin, ON L1M 1B1

905-655-0752

Confidential Case History Form

Name: _____ Tel.#. Home: () _____

Address: _____ Cell: () _____

City: _____ Prov.: _____ Postal Code: _____

Date of Birth: ____/____/____ Wt: _____ Ht: _____ Occupation: _____
d m y

Email Address: _____

Would you like e-mail reminders for appointments? Yes No

Present Complaint: _____

Previous Treatment for this complaint: _____

Have you had Massage Therapy Treatment before? Yes No

Overall, how is your general health? _____

Current Medication(s): _____ Prescribed for: _____

_____ Last taken: _____

Allergies to nuts, oils, or creams? _____ Anaphylaxis/Skin irritation? _____

Referral? How did you hear about us?: _____

Physician: _____

Address: _____

Phone: () _____ - _____

Date of Last Visit: ____/____/____

Other Healthcare:

Now / Past

Chiropractic

Physiotherapy

CONSENT & OFFICE POLICY:

1) I understand and agree that payment is due at the requested appointment time. The Brooklin Natural Health Centre requires **a minimum of 24 hours notice of any appointment changes. Failure to give sufficient notice or to appear at the pre-booked time will result in a 50% charge for the missed appointment.** This charge will not be covered by my Extended Health insurance.

2) I feel informed as to the treatment outlined by the therapist, and therefore consent to receive the therapy prescribed.

Patient Signature

Date

Witness

Health History

Please indicate conditions which you are now experiencing or have experienced in the past...

Now / Past Head/Neck

- headaches**
type _____
- vision problems
- contact lenses
- earaches
- migraines *aura*?

Respiratory

- chronic cough
- asthma
- smoking
- emphysema
- bronchitis

Cardiovascular

- high blood pressure
- low blood pressure
- poor circulation
- heart disease
- heart attack # _____
- pacemaker
- phlebitis
- stroke
- varicose veins
Dr. diagnosed? _____

Infectious Conditions

Yes / No

- Tuberculosis
- AIDS/HIV
- Hepatitis
type _____
- Infectious skin condition
location _____

Additional information that you feel is relevant to the therapist? _____

Now / Past Skin

- skin conditions**
type _____
- bruise easily
- loss of sensation
where _____

Other Conditions

- Crohn's disease
- Colitis
- constipation
- Liver /gall bladder
- Kidney / bladder
- Diabetes: *onset* _____
- cancer _____
- Arthritis _____
(*type & areas affected*)
- Fibromyalgia
- Osteoporosis
- Post-Polio syndrome
- Scoliosis
- Hemophilia
- Epilepsy

Now / Past Misc.

- Muscle Strain
- Ligament Sprain
- Tendinitis/ Bursitis
- Fracture
location _____
- Whiplash
when _____
- disc herniation
where? _____

Now / Past Women

- menstrual problems
- pain
- pregnant
due _____
of children _____
- gyne surgery
type _____
- menopausal problems

Muscles / Joints

Now / Past Pain or Stiffness

- neck
- low back
- mid back
- upper back
- shoulders
- hip
- knee
- ankle
- other _____

Surgery

Type: _____

Date: _____

Pins, wires, artificial joints?

Type: _____

Date: _____

Pins, wires, artificial joints?

Updates: Yearly



