Central Avenue Health Centre
Confidential Patient Case History

DATE: _____

Contact Information

FIRST NAME: _____ LAST NAME: _____

ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

TELEPHONE CELL: _____ HOME: _____ WORK: _____

EMAIL: _____ BIRTHDATE: mm/dd/yy _____

OCCUPATION: _____ HEALTH CARD NUMBER: _____

FAMILY DOCTOR: _____

HOW DID YOU HEAR ABOUT US? _____

MAY WE THANK THEM FOR REFERRING YOU? YES NO

EMERGENCY CONTACT INFORMATION

NAME: _____ PHONE NUMBER: _____

Prior Care

HAVE YOU HAD PREVIOUS MASSAGE THERAPY? YES NO

BY WHOM? _____ WHEN? _____

DO YOU HAVE ANY SKIN ALLERGIES TO LOTIONS OR OILS? _____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES NO

BY WHOM? _____ WHEN? _____

HAVE YOU EVER HAD X-RAYS TAKEN OF YOUR SPINE?

YES NO WHEN? _____

Medical History

ARE YOU CURRENTLY PREGNANT? YES NO

ARE YOU TAKING PRESCRIPTION OR OVER THE COUNTER MEDICATION? YES NO

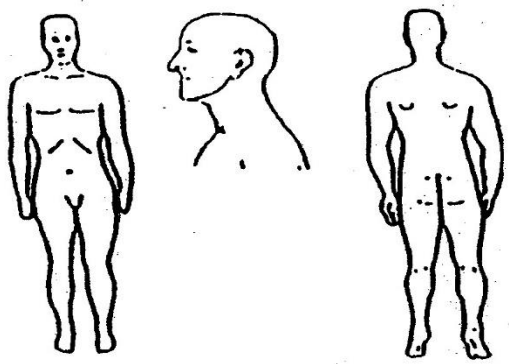
IF YES, WHAT TYPE? _____

DESCRIBE ANY PERSONAL ACCIDENTS OR INJURIES AND WHEN THEY OCCURRED?

_____

LIST ANY SURGICAL OPERATIONS? _____

_____



← CIRCLE YOUR AREA(S) OF DISCOMFORT

YOUR APPROXIMATE:

HEIGHT _____

WEIGHT _____

CHECK IF YOU HAVE (OR HAVE EVER HAD) ANY OF THE FOLLOWING:

- □ **FIBROMYALGIA**
- □ **HEART DISEASE**
- □ **HEPATITIS**
- □ **HERPES**
- □ **HERNIA**
- □ **VISUAL DISTURBANCE**
- □ **RHEUMATIOD ARTHRITIS**
- □ **HIGH BLOOD PRESSURE**
- □ **SEIZURES**
- □ **DIABETES I/II**
- □ **HIGH CHOLESTEROL**
- □ **SWOLLEN JOINTS**
- □ **OSTEOPOROSIS**
- □ **EASY BRUISING**
- □ **LOW BLOOD PRESSURE**
- □ **VARICOSE VEINS**
- □ **OSTEOARTHRITIS**
- □ **STROKE**
- □ **CANCER**
- □ **ANEMIA**
- □ **PHLEBITIS**
- □ **HIV**

OTHER MEDICAL CONDITIONS: _____

REASON FOR TODAY'S VISIT _____

_____

HOW LONG HAVE YOU HAD YOUR COMPLAINT? _____

HOW DID IT START? _____

WHAT MAKES IT WORSE? (E.G. SITTING, STANDING, LIFTING) _____

_____

IF YOU HAVE NO SYMPTOMS OR COMPLAINTS, AND ARE HERE FOR WELLNESS CARE,

PLEASE CHECK HERE ☐