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

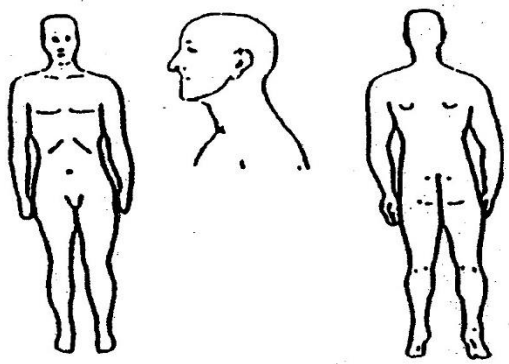
ARE YOU TAKING PRESCRIPTION OR OVER THE COUNTER MEDICATION? YES NO
IF YES, WHAT TYPE? _____

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:

□ **HEADACHES**	□ **STROKE**	□ **ASTHMA**
□ **DIZZINESS**	□ **HIGH CHOLESTEROL**	□ **CANCER**
□ **VISUAL DISTURBANCE**	□ **HIGH BLOOD PRESSURE**	□ **HERNIA**
□ **RHEUMATIOD ARTHRITIS**	□ **LOW BLOOD PRESSURE**	□ **PMS/CRAMPS**
□ **FIBROMYALGIA**	□ **HEART DISEASE**	□ **HERPES**
□ **OSTEOARTHRITIS**	□ **DIABETES I/II**	□ **ALLERGIES**
□ **SWOLLEN JOINTS**	□ **ANEMIA**	□ **CONSTIPATION**
□ **NECK PAIN**	□ **VARICOSE VEINS**	□ **SENSITIVE SKIN**
□ **MID BACK PAIN**	□ **PHLEBITIS**	□ **NUMBNESS/TINGLING**
□ **LOW BACK PAIN**	□ **POOR CIRCULATION**	□ **HIV**
□ **OSTEOPOROSIS**	□ **EASY BRUISING**	□ **HEPATITIS**
□ **SEIZURES**	□ **DEPRESSION**	□ **ANXIETY**
□ **BAD TEMPER**	□ **EASILY STRESSED**	□ **INSOMNIA**
□ **VERTIGO**	□ **SINUS PROBLEMS**	□ **DIARRHEA**

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 ☐