RIVER STONE
Massage & Wellness Centre

Date ________________

PHYSIOTHERAPY

Confidential Patient Case History Form

Name: ______________________________ Birthdate: (Day)________ (Month)________ (Year)________

Email: ______________________________ Home Phone: _______________ Cell: _______________

Physician: ________________________ Has your physician seen you for your current problem? ❒ Yes ❒ No

Names of other Healthcare Providers you are seeing for your problem:

____

I currently have, or in the past had the following health issues (check all that apply):

❒ Arthritis	❒ Dizziness	❒ Stroke	❒ Hepatitis
❒ Rheumatoid Arthritis	❒ Falling Spells	❒ Coronary Artery Disease	❒ Asthma
❒ Osteoporosis	❒ Bladder Incontinence	❒ Pacemaker	❒ Allergies
❒ Fibromyalgia/Chronic fatigue	❒ Bowel Incontinence	❒ Depression	❒ COPD
❒ Diabetes Type_______	❒ IBS	❒ Anxiety	❒ Current Smoker
❒ Thyroid Problems	❒ Crohn's Disease	❒ IUD	❒ Skin Condition
❒ High Cholesterol	❒ Celiac Disease	❒ Mood Disorder	❒ HIV/AIDS
❒ Migraines/Headaches	❒ Chronic Constipation	❒ ADHD	❒ Substance Abuse
❒ Fainting	❒ Heart Attack	❒ Epilepsy/seizure	❒ Hiatal Hernia
	❒ High Blood Pressure		❒ Hearing loss

❒ Neurological Condition (Specify): ______________________________

❒ Cancer – Specify type, treatment undergone and approximate year: ______________________

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❒ Learning difficulties (specify): ______________________________

❒ Other: ____

Are you currently pregnant? ❒ Yes ❒ No

Please list ALL previous surgeries and (approximate) year they occurred:

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Please list ALL previous sustained injuries (e.g. car accident, falls, concussions, fractures, etc.) and approximate year they occurred:

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Please list all medications/supplements and reasons for taking them:

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What are your goals/expectations for treatment?

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Please list any other information you feel would assist us in ensuring your safety and optimize your care:

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The physiotherapist met with me, the client, to discuss my medical history. I understand the nature, benefits, potential risks, alternatives and consequences and agree with the outcome of this discussion and treatment.

For insured clients:
I hereby consent to direct billing so that River Stone Massage and Wellness Centre may bill my health insurance company and have that company pay River Stone directly for my treatments. By signing this I also state that I will pay any outstanding fees for treatments received that are not covered by my insurance company.

Cancellation:
We require 24 hours' notice if you need to cancel/change your appointment so that we may accommodate another client in need of our therapeutic services. If you cancel with less than 24 hours' notice, a $50.00 cancellation fee will be charged to your account and/or credit card. We hold encrypted credit card information on our secure server. If you forget or otherwise choose to forgo your appointment, we reserve the right to charge in full for your missed appointment.

______________________	____________	______________________
Client Signature	Date	Physiotherapist Signature