RIVER STONE
Massage & Wellness Centre

Date _____

# CHIROPRACTIC

Confidential Patient Case History Form

Name: _____ Occupation: _____ Gender: _____

Address: _____ City: _____ Postal Code: _____

Email: _____ Age:____ Birthdate: (Day)_____ (Month)_____ (Year)_____

AB Health Care #: _____ Home Phone: _____ Cell Phone: _____

Medical Doctor: _____ Doctor Phone #: _____

Emergency Contact Name: _____ Phone #: _____

How did you hear about us? (check one below)

❒ Google ❒ Facebook ❒ Instagram ❒ Storefront Sign ❒ River Stone Therapist: _____

❒ World Weight Loss Inc. ❒ Doctor or lawyer: _____ ❒ Other: _____

I agree that River Stone Massage may notify me of new treatments and promotions via email. ❒ Yes ❒ No

**Please indicate conditions you are experiencing or have experienced:**

**Cardiovascular**
❒ High blood pressure
❒ Low blood pressure
❒ Chronic congestive heart failure
❒ Heart attack
❒ Phlebitis / varicose veins
❒ Stroke / CVA
❒ Pacemaker or similar device
❒ Heart disease
❒ Dizziness / vertigo
❒ Seizures
❒ Blood clots

Is there a family history of any of the above? ❒Yes ❒No

**Head and Neck**
❒ History of headaches
❒ History of migraines
❒ Vision problems
❒ Vision loss
❒ Ear problems
❒ Hearing loss

**Women**
❒ Pregnancy
*Due Date:* _____
❒ Previous Pregnancy Complications:
*Describe:* _____
❒ Menopausal problems:
*Describe:* _____
❒ Menstrual problems:
*Describe:* _____
❒ Gynecological conditions
*Describe:* _____

**Respiratory**
❒ Asthma
❒ Bronchitis
❒ Emphysema
❒ Chronic Cough
❒ Shortness of breath

Is there a family history of any of the above? ❒ Yes ❒ No

**Muscle/Joint**
❒ Neck
❒ Back (❒ lower ❒ mid ❒ upper)
❒ Shoulders
❒ Elbow
❒ Wrist / Hand
❒ Hip
❒ Knee
❒ Ankle / Foot
❒ Spine

**Infectious Conditions**
❒ Skin Conditions
*Describe:* _____
❒ Respiratory Conditions
*Describe:* _____
❒ Hepatitis

**Skin Conditions**
❒ Eczema
❒ Psoriasis
❒ Rash
❒ Warts
❒ Open Sores

**Digestive**
❒ Constipation
❒ Crohn's Disease
❒ Colitis
❒ Irritable Bowel Syndrome
❒ Ulcers

**Other**
❒ Loss of sensation
*Where?* _____
❒ Diabetes
*Onset:* _____
*Type:* _____
❒ Allergies / hypersensitivity
*What?* _____
❒ Epilepsy
❒ Cancer
*Type/Location:* _____
❒ Arthritis
*Type/Location:* _____
❒ Hemophilia
❒ Fibromyalgia
❒ Chronic fatigue
❒ Scoliosis
❒ Polio / Post Polio
❒Osteoporosis
❒Thyroid Problems

Is there a family history of any of the above? ❒ Yes ❒ No

**Men**
❒ Enlarged Prostate
❒ Libido Issues
❒ Other
_____

**Do you have any medical conditions not listed above?** ❒ Yes ❒ No

*If yes, please describe:* _____

_____

**Do you have any internal wires, artificial joints, pacemakers or special equipment that we should be aware of?**

❒ Yes ❒ No *If yes, please describe:* _____

_____

**<u>Please circle any area causing you symptoms of pain, stiffness, numbness or other forms of discomfort:</u>**

| | | | | | | |
|---|---|---|---|---|---|---|
| Face | Upper Back | Arm(s) | Hand(s) | Thigh(s) | Ankle(s) | Neck |
| Elbow | Mid Back | Finger(s) | Knee(s) | Feet | Shoulder(s) | Wrist(s) |
| Hip(s) | Lower Back | Leg(s) | Toe(s) | Chest | Ribs | Tailbone |

**For what condition or reason are you seeking treatment today?** _____

_____

**Have you seen any other health care professional(s) for this condition or reason?** ❒ Yes ❒ No

**Have you ever been involved in a motor vehicle accident?** ❒ Yes ❒ No Date:_____

**Have you been involved in any other accidents?** ❒ Yes ❒ No Date:_____

**Have you ever been knocked unconscious?** ❒ Yes ❒ No Date:_____

**Have you ever had a work-related injury?** ❒ Yes ❒ No Date:_____

**Briefly explain any surgeries you have undergone, for what and when:**

_____

_____

**Have you had recent X-rays and if so what were the findings?**

_____

_____

**Are you presently taking any prescribed medication(s)?** ❒ Yes ❒ No

*If yes, please note the medication(s) and the condition(s) for which it is being used if known.*

_____

_____

**Have you previously received chiropractic treatment?** ❒ Yes ❒ No

*If yes, were you treated:* ❒ At this clinic ❒ Other

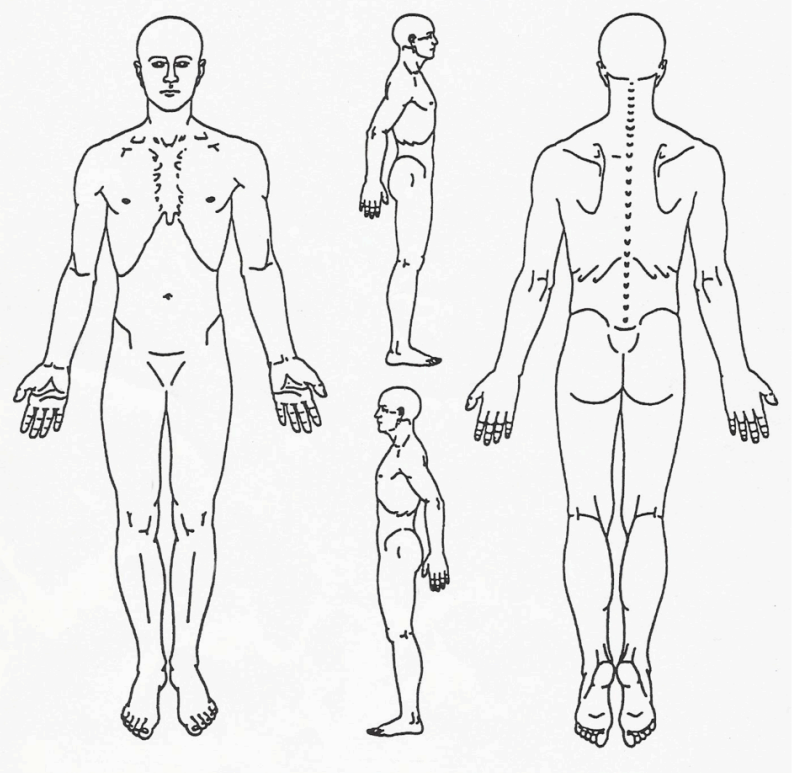
**Have you ever had your neck adjusted?** ❒ Yes ❒ No

**Are, or were, you a smoker?** ❒ Yes ❒ No

**Please rank your stress levels?** ❒ Low ❒ Medium ❒ High ❒ Very High

**Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Mark areas where pain radiates or spreads with arrows ↑, ↓, ←, → to indicate the direction of radiating pain. Include all affected areas.**

| | | | |
|---|---|---|---|
| A = Ache | B = Burning | R = Radiating Pain | D = Dull Pain |
| N = Numbness | S = Stabbing | P = Pins & Needles | O = Other |



**Please indicate how you would rate your pain** (LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

**How long have you experienced this pain?** ❒ Years ❒ Months ❒ Weeks

**Is this your first episode of this pain?** ❒ Yes ❒ No

**Are you submitting treatments to WCB?** ❒ Yes ❒ No

**I acknowledge that no assurance or guarantee has been provided as to the results of the treatment. I understand that the Chiropractor must be fully aware of my existing medical conditions. I have completed my medical history form as provided by River Stone Wellness Centre and disclosed all of those medical conditions affecting me. It is my responsibility to keep the Chiropractor updated on my medical history. I give consent for my treatment notes to be read by the other health care professionals at River Stone Wellness Centre. The information I have provided is true and complete to the best of my knowledge.**

**For insured clients:**
**I hereby consent to direct billing so that River Stone Wellness Centre may bill my health insurance company and have that company pay River Stone Wellness Centre 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 $30.00 cancellation fee will be charged to your account and/or credit card. We hold encrypted credit card information on our secure server.**

| Signature | Date | Chiropractor Signature |
|---|---|---|