RIVER STONE
Wellness Centre

Date _____

PHYSIOTHERAPY

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 check any of the following that you are experiencing:</u>

❒ Fever/chills ❒ Night sweats/sweats ❒ Sudden weakness ❒ Night pain ❒ Weight loss
❒ Loss of sleep ❒ Clumsiness ❒ Dropping things suddenly

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 physiotherapy? ❒ Yes ❒ No

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

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

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

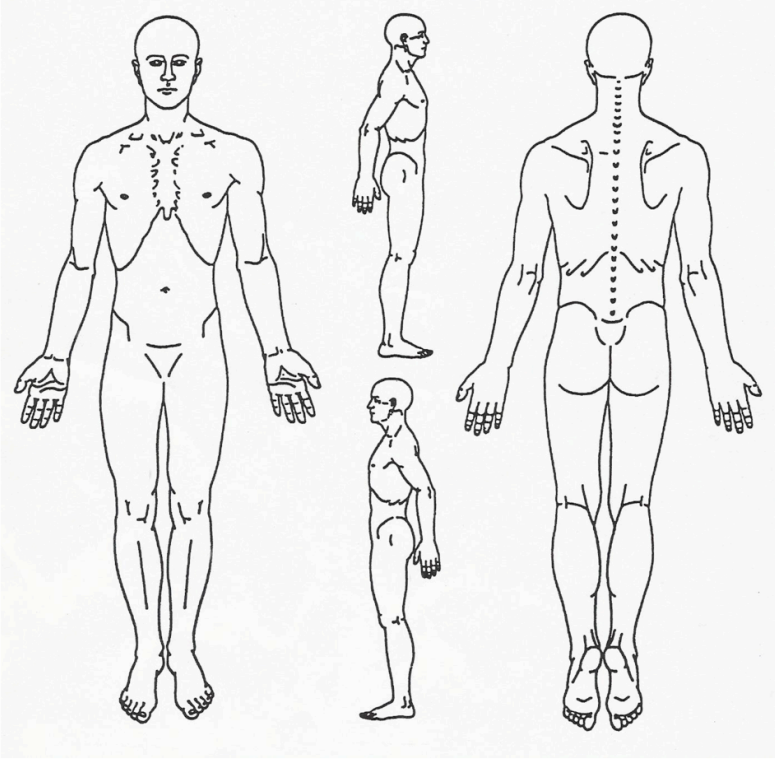
Do you tend to feel better in the morning or evening? ❒ Morning ❒ Evening

Do you feel better sitting or standing? ❒ Sitting ❒ Standing

Does a cough/sneeze or deep breathe change your pain? ❒ Yes ❒ No

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 Physiotherapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by River Stone and disclosed all of those medical conditions affecting me. It is my responsibility to keep the Physiotherapist updated on my medical history. I give consent for my treatment notes to be read by the other health care professionals at River Stone. 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 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.

_____	_____	_____
Signature	Date	Physiotherapist Signature