CONFIDENTIAL CLIENT CASE HISTORY

NAME | AGE | DATE OF BIRTH (MM/DD/YY) | GENDER

ADDRESS | CITY | POSTAL CODE

PHONE NUMBERS (HOME/CELL/WORK) | EMAIL ADDRESS

PHYSICIAN'S NAME | CLINIC | HEALTH CARD NUMBER

CURRENT MEDICATIONS

OCCUPATION | EMPLOYER | SPORTS & ACTIVITIES

REASON FOR TODAY'S TREATMENT

Have you been to a massage therapist before? ❍ Yes ❍ No Date of last treatment: _____

Are you under any medical supervision presently? ❍ Yes ❍ No

Are you Pregnant? ❍ Yes ❍ No How many weeks? _____ Due Date: _____

Did the current injury result from a Motor Vehicle Accident or Workplace Injury?

IF YES, WHAT IS YOUR SGI OR WCB CLAIM #

RCMP/VETERANS #

Are you under medical care for any of the following:

- ❍ Heart conditions
- ❍ Varicose veins
- ❍ Neck injury
- ❍ Osteoporosis
- ❍ Cancer
- ❍ Diabetes
- ❍ Crohn's disease
- ❍ Nervous disorders
- ❍ High/low blood pressure
- ❍ Circulatory problems
- ❍ Back injury
- ❍ Rheumatoid arthritis
- ❍ Kidney disease
- ❍ Asthma/respiratory
- ❍ Pelvic inflammatory disease
- ❍ Whiplash
- ❍ Osteoarthitis
- ❍ Fainting or dizziness
- ❍ Headaches or migraines
- ❍ Jaw or ear pain
- ❍ Skin conditions
- ❍ Fibromyalgia
- ❍ Epilepsy
- ❍ Multiple sclerosis
- ❍ Other: _____

Have you received care from any of the following?

❍ Chiropractor ❍ Physiotherapist ❍ Naturopath ❍ Acupuncture

❍ Other: _____

Have you had surgery in the past? ❍ Yes ❍ No

IF YES, FOR WHAT?

Have you had any fractures/sprains in the past? ❍ Yes ❍ No

IF YES, WHERE?

#60–3211 Preston Avenue, Saskatoon SK S7T 1C9 (306) 955 8808 **f** 955 8809 **foundationchiropractic.ca**

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Have you had any serious illnesses in the past? ❍ Yes ❍ No

IF YES, WHAT?

Have you had any of the following regarding your current condition?

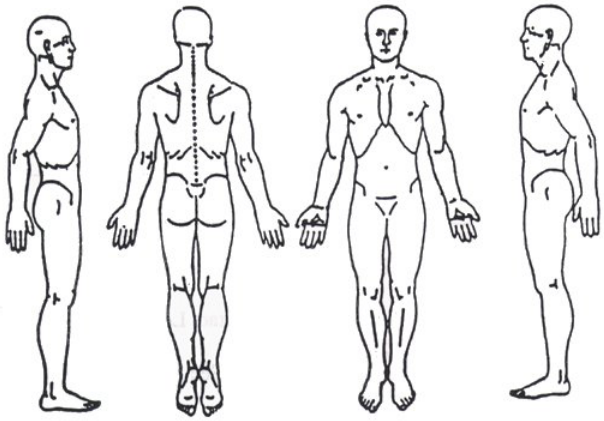
❍ Physician's examination ❍ X-ray ❍ Other diagnostic tests such at CT, MRI, etc.

Do you have any allergies? Sensitivities? ❍ Yes ❍ No

IF YES, PLEASE LIST

What relieves your pain?

Please circle on the following diagram the affected areas of concern.



Missed Appointment / Cancellation Policy

PLEASE READ CAREFULLY

Your appointment time is reserved especially for you. If you are unable to keep your allotted time, we require notification of **24 hours**.If you are unable to provide the required 24 hours, **Cancellations & Missed Appointments will be charged the FULL PRICE OF TREATMENT TIME** booked**.** Receipts will not be issued for missed or cancelled appointments. This fee is not redeemable through insurance companies for reimbursement.

Waiver

Because a Massage Therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the Massage Therapist updated on my physical and mental health. The information contained on this form is true to the best of my knowledge. I give my permission that my therapist may obtain and submit reports regarding my condition to/from my physician as may be required.

I understand and I am informed that in the practice of Massage Therapy, as in all other forms of health care, there are some risks to treatment including, but not limited to muscle soreness and stiffness. I acknowledge that I have the right at any time to ask any questions I may have regarding my treatment.I understand that I may ask the massage therapist to stop treatment at any time.

SIGNATURE OF PATIENT / GUARDIAN

DATE (MM/DD/YY)

WITNESS

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