Date: ____________________ **Confidential Case History**

Full Name: ____________________ Birthdate: __________ (mm/dd/yyyy) Gender: M / F / Other: __________

Email Address: ____________________ Carecard No.: ____________________

Address: ____________________ City: ____________________ Postal Code: ____________________

Ph. No. Home: ____________________ Cell: ____________________ Work: ____________________

Occupation: ____________________ Your Medical Doctor's Name: ____________________

Who were you referred by? Friend (Name) ____________________ Other: ____________________

Hobbies/Recreation: ____________________

Briefly describe the conditions or reasons you are coming in for treatment: ____________________

How long have the above reasons/conditions existed? ____________________

Do you regard your conditions to be: Severe ☐ Moderate ☐ Mild ☐

Please check if you are currently receiving treatment from any of the following:

Medical Doctor ☐ Chiropractor ☐ Naturopath ☐ Physiotherapist ☐ Other: ____________________

Are you presently involved in:

An active ICBC claim? ☐ Yes ☐ No WorkSafeBC Claim? ☐ Yes ☐ No

We are unable to accept WSBC Claims/Injuries

Please list previous illness/accidents/surgeries that you have had (please note date and type):

____

Please list any **medications** you are currently using, including non-prescription:

____

Please list any **supplements** you are currently taking (vitamins, minerals, amino acids, etc.)

____

What is your goal in seeking treatment for your condition (i.e. total resolution, pain free movement, etc.)?

____

Are you willing to make some changes in your lifestyle, if necessary, to resolve your condition? ☐ Yes ☐ No

Explain: ____

____

What is your daily **WATER** intake? (Not including fruit juice, coffee, tea, soft drinks, alcohol, etc.)

☐ 2 Litres or more ☐ 1 Litre ☐ 500 mL ☐ Less than 500 mL

Briefly describe your diet (fast food, processed food, natural foods, etc.)

____

____

Are your bowel movements: ☐ Daily ☐ Less than daily Do you smoke cigarettes? How many per day? ________

How often do you exercise? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

On a scale of 1 (low) to 10 (high) what is your daily energy level? _______ Where do you want it to be? ________

Do you use orthotics in your shoes? ☐ Yes ☐ No | ☐ Custom Made ☐ Off the shelf

If you are female: Are you pregnant? ☐ Yes ☐ No | If yes, what is your due date? ____________________

Menstrual Cycle ☐ regular ☐ irregular ☐ painful ☐ heavy ☐ menopausal ☐ other: ______________

Do you have children? If so, how many and indicate if natural or caesarean delivery: ____________________

____

Please check if you presently have, or have had in the past, any of the following conditions:

	Present	Past
Arthritis		
Contagious Disease		
Cancer		
Cardiovascular Disease		
Chronic Infection		
Diabetes		
Digestive Ulceration		
Osteoporosis		
Tuberculosis		

	Present	Past
Epilepsy		
Fibrositis/Fibromyalgia		
Head or Neck Trauma		
High Blood Pressue		
Haemophilia		
Kidney Disease		
Rheumatism		
Spinal Disc Injury/Disease		
Skin Conditions		

Please check any of the following conditions currently bothering you:

	Slight	Mod.	Severe
Painful Muscle Tension			
Muscular cramps			
Sore aching joints			
Frequent cracking or popping sounds in joints			
Restricted joint movement			
Ligament sprain			
Muscle Sprain			
Joint dislocation			
Pain on walking			
Sore Feet			
Painful Legs			
Low back pain			
Mid-back Pain			
Upper back/ Shoulder Pain			
Pain in arms/wrists/hands			
Neck Pain			
Headaches			
Skin Infection			
Psoriasis			
Eczema			

	Slight	Mod.	Severe
Digestive Problems			
Nausea			
Abdominal cramps			
Painful bowel movements			
Loss of bowel or bladder control			
Menstrual problems			
Pelvic inflammation			
Urinary Infection			
Prostate Infection			
Cold or Flu			
Allergies			
Asthma			
Bronchitis			
Dizziness/Light headed			
Cold hands/feet			
Excessive sweating			
Varicose veins			
Anxiety			
Feeling depressed			
Sudden weakness			

Patient Consent

Randy Savard, BA, RMT will make every effort to ensure that your treatment is safe and effective. The approach to treatment may vary depending upon your condition(s). At any time before or during the massage therapy treatment, you have the right to ask that the treatment, or portion of the treatment, be discontinued.

All information within your file will be kept confidential and will not be released without your prior consent. You will be required to pay for any treatment related fees which have not been or are not covered by your health insurance.

Randy Savard, BA, RMT does not accept WorkSafeBC Claims or injuries. We are able to direct bill to most insurance companies, or we accept credit, debit or cash if paying privately for your treatments.

Please sign below to indicate that you have read and understood the above and that the information you provided in this case history form is accurate.

NOTE: If you are unable to keep an appointment, and have failed to give 24 hours' notice, the full treatment fee will be charged to your account which is due before your next appointment. Missed appointment fees cannot be billed through extended benefits or insurance. Your B.C. MSP visits will not be affected.

Signature of patient (or guardian if under 18 yrs.): ________________________________ Date: ______________________