

Theraputix, the Wellness Centre Inc.

Client Health History

Name: _____ Home Phone #: _____

Address: _____ Business Phone #: _____

City: _____ Postal Code: _____ Date of Birth: _____

E-mail address: _____

Emergency Contact (Name & Phone #): _____

Family Physician (Name, Address, Phone #): _____

Occupation: _____ How did you hear about us? _____

What brings you in for a treatment? _____

Health History Information

*Prioritize the areas of your body that you would prefer to receive treatment _____

*Have you taken any anti-inflammatory medication, pain killers (including aspirin, Advil etc.), muscle relaxants or mood altering medication within the past two hours? Yes No
If yes, What and how much? _____

*Are you currently seeing a medical practitioner? Yes No. If yes, please explain _____

*List any stress reduction exercises you do on a regular basis (include frequency) _____

Previous History

Surgeries: (include year and type of surgery) _____

Accidents: (include year and type of accident) _____

Of special note:(pins, wires, artificial joints/limbs etc.) _____

Please indicate if any of the following conditions apply to you (past or present):

Current Medications

Please provide the name of the Medication and what condition it is for: _____

Head/Neck

- Headaches: Type _____ (Tension/ Migraine?)
- Neck Pain/Injury
- Whiplash: Date: _____
- Tooth/Jaw/Ear pain
- Vision problems (contacts/Glasses)
- Head trauma/concussion
- Loss of Coordination
- Hearing problems

Respiratory System

- Asthma/Bronchitis
- Chronic cough
- Emphysema
- Shortness of breath
- Are you a smoker? Heavy or Light? _____
- Sinus problems
- Allergies/hay fever
- Pneumonia

Please turn over....>

Muscles/Joints

- Muscle cramps: Where? _____
- _____
- Sprain/strain:
Where/When? _____
- Tendonitis/ Bursitis:
Where? _____
- Limitation of Movement:
Where? _____
- Work/ Sports Injury
- Fractures/Bone Disease:
Where/ When? _____
- Disc Degeneration/ Herniation
- Osteo/Rheumatoid Arthritis
- Scoliosis
- Osteoporosis

Specific Muscle/Joint Pain

- Neck
- Low/ Mid/ Upper back
- Shoulders/ Arms
- Hip/ Leg/ Knee/ Ankle
- Other: _____

Nervous System

- Multiple Sclerosis
- Parkinson’s Disease
- Sciatica/ Hip pain
- Weakness/ Paralysis
- Numbness/tingling
- Herpes/Shingles
- Epilepsy/Seizures

Heart/Circulation

- High blood pressure
- Low blood pressure
- Heart attacks/ stroke
- Chest pain/ Angina
- Pacemaker
- Chronic congestive heart failure
- Edema/Swelling: Where?

- Dizziness
- Poor circulation
- Varicose veins
- Phlebitis
- Blood clots

Digestive System

- Constipation/ Diarrhea
- Nausea/ vomiting
- Heartburn/ indigestion/ gas
- Rapid weight loss
- Appetite changes
- Ulcers
- Jaundice
- Abdominal pain
- Diverticulitis/colitis/
- Crohn’s disease
- Irritable Bowel Syndrome

Other Healthcare Received, Past or Present

- Chiropractic
- Physiotherapy
- Psychotherapy
- Massage- Date of last message _____

Skin

- Open sores/cuts/warts
- Rashes/ Athlete’s foot
- Eczema/ Psoriasis
- Bruise easily
- Other skin conditions:
Type: _____

Infectious Conditions

- Tuberculosis
- HIV/ AIDS
- Hepatitis- Type _____
- Infectious skin conditions. Where? _____

Female

- Menstrual problems (painful, heavy, scant)
- Pregnant? Due date _____
- Any complications? _____
- _____
- Menopausal problems
Type: _____

Other

- Diabetes: Type? _____
Onset: _____
- Thyroid Issues
- Sleep Disturbances
- Thoracic Outlet Syndrome
- Fibromyalgia
- Carpal Tunnel Syndrome
- Hemophilia
- Cancer-
Location: _____

Date of last check-up: _

For Your Information:

An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future, please be sure to let me know. This form must be updated annually. All information gathered for this treatment is confidential and will be released to other health care professionals or legal representatives only upon your written consent. Information may be shared with your other health care practitioners here at “Theraputix”, in order to maximize your health care goals. Please inform us if you *do not* wish for that to occur. Please be aware that you may request to stop or alter the treatment at any time for any reason and the therapist will comply with your wishes. **Although the upmost care will be taken to ensure safety and comfort for the patients, in the event of injury our clinic, Theraputix The Wellness Centre Inc. will not be held liable for any reason.**

Cancellation Policy: Please note that **24 hours advance notice is required for cancellation of all appointments;** otherwise you will be charged for the missed visit.

Consent:

I have read and understand the above and give my consent to receive treatment.

Guardian Name (If Applicable): _____ Signature: _____

SIGNATURE (client): _____ DATE: _____