Shelbourne Physiotherapy & Massage

Confidential Case History

Name: ______________________________ Care Card #: ______________
First Middle Last

Address: ______________________________ Postal Code: ______________

Home Phone: ______________ Work: ______________ Cell: ______________

Email: ______________________________

Family Doctor: ______________ Referring Physician: ______________

Occupation: ______________________________ Date of Birth: ______________
Month / Day / Year

How did you hear about us? ______________________________

ICBC/WCB Claim # ______________ Date of Injury: ______________

Adjuster: ______________________________

What is your chief complaint? – Describe condition: ______________________________

____

Describe onset: ❑ Sudden ❑ Gradual - Duration? ______________

Cause of Injury: ______________________________

Quality of Pain: ❑ Sharp ❑ Burning ❑ Dull ❑ Aching
❑ Tingling ❑ Shooting ❑ Other: ______________

Pain Patterns: ❑ Constant ❑ Occasional ❑ Periodic
❑ Static ❑ Increasing ❑ Decreasing

What aggravates the pain?: ______________________________

What relieves the pain?: ______________________________

What is your pain level?: Low <-0 ---- 1 ---- 2 ---- 3 ---- 4 ---- 5 -> High

Has this condition occurred before?: ❑ Yes ❑ No If yes, was it resolved?: ❑ Yes ❑ No

List medications or other remedies taken or currently taking: ______________

____

Are you involved in any extra-curricular activities or sports? ______________

____

Have you had any serious past injuries, accidents, surgeries, illness? Please date and explain: ______________

____

Are you currently seeking, or have in the past, seen a practitioner for this condition?

- ❑ Medical Doctor
- ❑ Massage Therapist
- ❑ Physiotherapist
- ❑ Chiropractor
- ❑ Acupuncturist
- ❑ Other: ______________________________

Please indicate which of the following apply, and whether they are past or present concerns:

- ❑ Cardiovascular Condition*
- ❑ High/Low Blood Pressure
- ❑ Diabetes
- ❑ Respiratory Condition*
- ❑ Pregnancy
- ❑ Osteoporosis
- ❑ Rheumatoid or Osteoarthritis
- ❑ Stroke
- ❑ Headaches
- ❑ Allergies*
- ❑ Skin Condition*
- ❑ Cancer*
- ❑ AIDS/HIV
- ❑ Hepatitis
- ❑ Other Disease/Condition
- ❑ Kidney Condition
- ❑ Digestive Conditions*
- ❑ Seizures
- ❑ Dislocation/Fractures
- ❑ Bruise Easily
- ❑ Insomnia
- ❑ Smoking
- ❑ Swelling
- ❑ Sprains/Strains

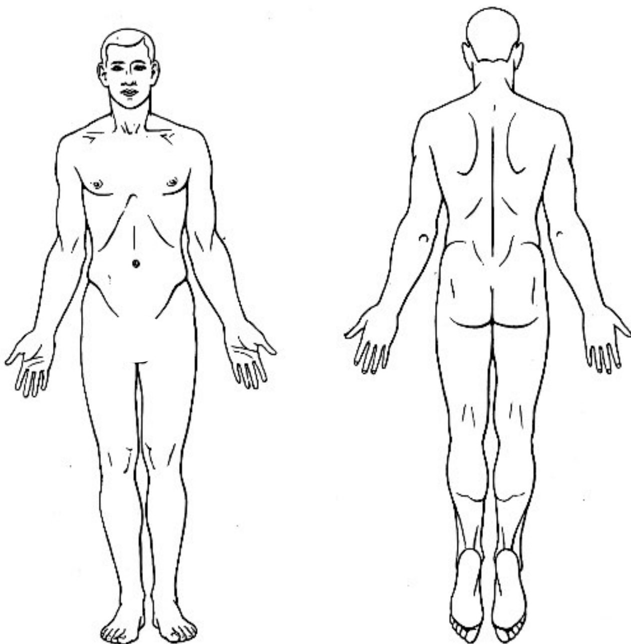
*Please Specify: ______________________________

Comments: ______________________________

I hereby declare that the above information is accurate and complete to the best of my knowledge. I have disclosed all relevant past and present health information known to date and agree to inform my therapist of changes to the above information, if any, as they occur. **I understand that 24 hours cancellation notice is required or a full appointment fee will be charged.** I consent to a massage therapy treatment.

Signed: ______________________________ Date: ______________

For Office Use Only:



Functional Tests: ______________________________

Special Tests: ______________________________

Neurological Examination: ______________________________

Other: ______________________________

Your personal information is being collected, used, and disclosed only in compliance with the BC *Personal Information and Protection Act.*