CURAVITA
Chiro • Massage • Physio

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CONFIDENTIAL CASE HISTORY

Date: _____

Your answers will help us determine if our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case but will work to refer you to the appropriate health care provider. If you need help with this form, please do not hesitate to ask us.

PERSONAL INFORMATION

Name: ❑ Mr. ❑ Mrs. ❑ Ms ❑ Miss ❑ Dr. _____

_____

How do you wish to be addressed in our office?

❑ First Name ❑ Mr. ❑ Mrs. ❑ Ms ❑ Miss ❑ Dr.

Marital Status: ❑ M ❑ S ❑ W ❑ D

Address: _____

City: _____

Postal Code: _____

Home Phone: _____

Business Phone: _____

Date of Birth: dd_____mm_____yr_____

e-mail address: _____

Employer: _____

Address: _____

_____

Occupation: _____

Hobbies: (What occupies your spare time?) _____

_____

Spouse's or Partner's Name: _____

Employer: _____

Telephone:_____

How did you hear about our office? _____

Medical Doctor's Name: _____

Would you like a medical report forwarded to your MD? ❑ Yes ❑ No

I consent to the clinic to communicate electronically with me for the purpose of scheduling appointments, appointment confirmations, clinic updates and newsletters. ❑ Yes ❑ No

HEALTH INFORMATION

Have you ever been to a physiotherapist before?

❑ No ❑ Yes, Name: _____

When was your last visit? _____

What was the problem? _____

Have you had previous healthcare for this problem? ❑ Yes ❑ No

Where? _____

When? _____

Were x-rays taken? _____

REASON FOR CONSULTING OUR OFFICE

What is your major complaint? _____

Is this complaint a result of a motor vehicle accident? ❑ No ❑ Yes

Is this a Workman's Compensation case? ❑ No ❑ Yes

How long have you had this condition?_____

Have you had this or similar conditions in the past?

❑ No ❑ Yes, and when? _____

What activities aggravate your condition? _____

What makes it better? _____

Is this condition getting progressively worse?

❏ Yes ❏ No ❏ Constant ❏ Comes and goes

Is this condition interfering with your ❏ Work ❏ Sleep ❏ Daily Routine ❏ Other_____

Has there been any medical diagnosis of your complaint? ❏ No ❏ Yes, if yes list the Dr.'s name and diagnosis: _____

_____

List surgical operations and years: _____

_____

List any Prescription Drugs, Over the counter Drugs, Vitamins and Natural Supplements you are currently taking: _____

_____

Do you wear:

❏ Heel Lifts ❏ Sole Lifts ❏ Inner soles ❏ Arch supports ❏ Orthotics

Have you had any other personal injury or accident:

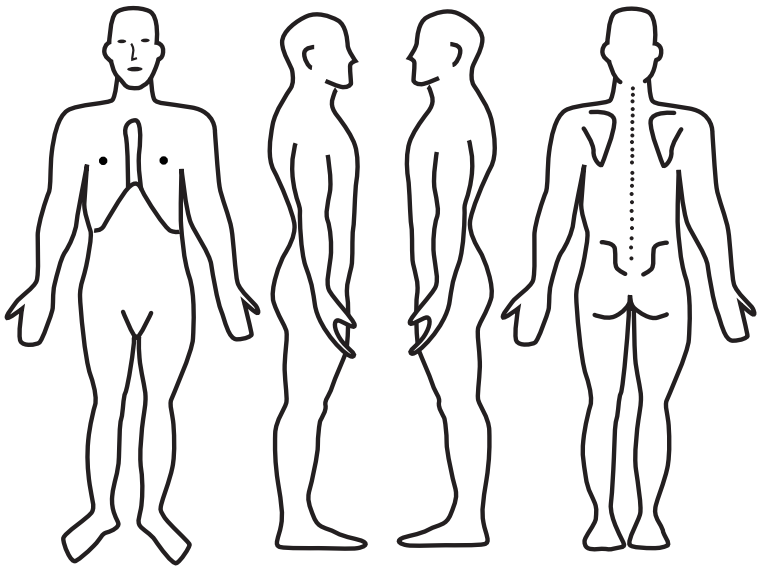
❏ None ❏ Past year ❏ Past 5 years ❏ Over 5 years

Description of accident: _____

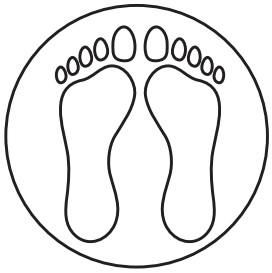
_____

Date of most recent physical examination: _____

Please mark the areas of pain and/or discomfort on the figures below:



Front Right Left Back



Please rate your current level of discomfort:

	No Pain					Moderate Pain					Unbearable Pain
Neck:	0	1	2	3	4	5	6	7	8	9	10
Mid Back:	0	1	2	3	4	5	6	7	8	9	10
Low Back:	0	1	2	3	4	5	6	7	8	9	10

Are you affected by any of the following?

Please check ❑ O = Occasionally F = Frequently C = Constantly

General Symptoms:	**O**	**F**	**C**
Diabetes	❑	❑	❑
Excessive sweating	❑	❑	❑
Night Sweats	❑	❑	❑

Neurological:	**O**	**F**	**C**
Headache	❑	❑	❑
Fainting	❑	❑	❑

Muscles and Joints:	**O**	**F**	**C**
Arthritis/Rheumatism	❑	❑	❑

Skin:	**O**	**F**	**C**
Bruise easily	❑	❑	❑
Hives/Skin Allergies	❑	❑	❑

Cardiovascular:	**O**	**F**	**C**
Bleeding Disorder	❑	❑	❑
High Blood Pressure	❑	❑	❑
Low Blood Pressure	❑	❑	❑
Chest Pain	❑	❑	❑
Stroke	❑	❑	❑
Arteriosclerosis	❑	❑	❑
Varicose veins	❑	❑	❑
Swelling of ankles	❑	❑	❑
Angina	❑	❑	❑
Irregular Heart Beat	❑	❑	❑

ENT:	**O**	**F**	**C**
Ring/buzz in ears	❑	❑	❑

Respiratory:	**O**	**F**	**C**
Asthma	❑	❑	❑
Difficulty breathing	❑	❑	❑
Wheezing	❑	❑	❑

Lifestyle:	**O**	**F**	**C**
Smoker	❑	❑	❑
If yes, how long?	❑	❑	❑
If yes, how much?	❑	❑	❑
Drink Alcohol	❑	❑	❑
If yes, how much?	❑	❑	❑
Exercise	❑	❑	❑

For Women:	**O**	**F**	**C**
Excessive Flow	❑	❑	❑
Hot Flashes	❑	❑	❑
Absent/Irregular Cycle	❑	❑	❑
Cramping/Backache	❑	❑	❑
Pregnant	Yes ❑	No ❑	

We thank you for your patience and cooperation in completely filling out this form.

Patient's Signature: _____ Dated: _____

Patient consent for examination_____
Physiotherapist's Initials