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: _____

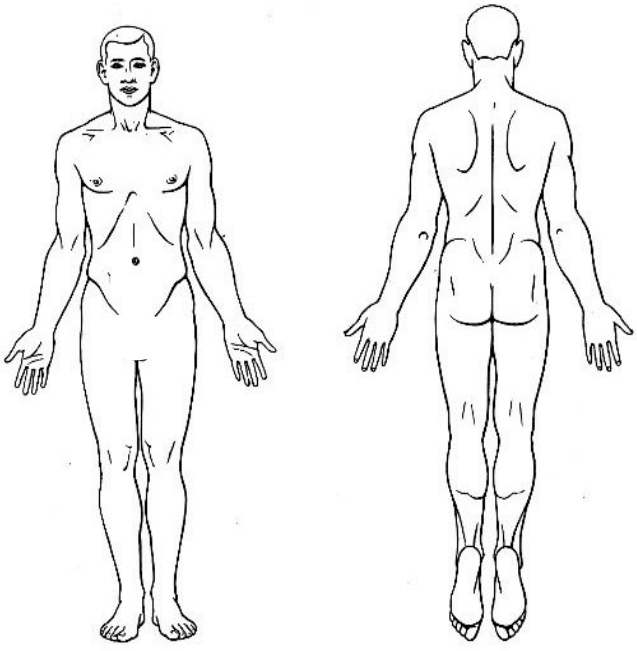
_____

_____

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.*