

CASE HISTORY FORM

(Patients over 15 years old)

NAME _____ DATE OF BIRTH D _____ M _____ Y _____

ADDRESS _____ PHONE (H) _____

CITY _____ POSTAL CODE _____ (W) _____

EMAIL _____

OCCUPATION _____

DOCTOR'S NAME _____ PHONE _____

Permission to consult with your doctor regarding your condition? No Yes

Do you currently have an active ICBC or WCB claim? No Yes, claim # _____

- Reason for treatment:

- Date of onset:

- Symptoms:

- Has this condition occurred before?

No Yes _____

- Are you taking medication for any reason?

No Yes _____

- Are you currently seeing another practitioner for any reason?

No Yes _____

- Are you satisfied with your :

Ability to relax	yes	no
Exercise	yes	no
Energy level	yes	no
Overall health	yes	no
Sleep	yes	no

- Please list all dental work performed (excluding fillings & cleanings):

MEDICAL HISTORY

P = Past **C = Current**

CHILDHOOD:

- Birth Trauma _____
- Feeding Problems _____
- Colic _____
- Recurrent ear infections _____
- Developmental delays _____
- Hyperactivity/ADD/ADHD _____
- Learning disabilities _____
- Eye motor problems _____
- Hospitalized for any reason _____

CARDIOVASCULAR:

- Heart condition _____
- Stroke _____
- High/Low Blood pressure _____
- Pacemaker etc. _____
- Arteriosclerosis _____
- Cardiovascular aneurysm _____
- Phlebitis or Varicose Veins _____

RESPIRATORY:

- Shortness of breath _____
- Bronchitis _____
- Asthma _____
- Emphysema _____

GASTROINTESTINAL:

- Heartburn _____
- Nausea _____
- Gas _____
- Constipation/Diarrhea _____
- Ulcer _____

HEAD & SPINE:

- Head injury _____
- Spinal injury _____
- Headaches _____
- Migraines _____
- Jaw pain / clicking / locking _____
- Whiplash _____
- Fainting / Dizziness _____
- Vision Problems _____
- Ear/Hearing problems _____
- Ringing in ears _____
- Sinus problems _____
- Facial pain _____
- Other neurological conditions _____

OTHER:

- Arthritis _____
- Infections _____
- Susceptible to colds/illness _____
- Insomnia _____
- Fatigue _____
- Skin conditions _____
- Pregnancy _____
- Cancer _____
- Epilepsy / Seizures _____
- Diabetes _____
- Hepatitis _____
- Kidney condition _____
- Contagious condition _____
- Other _____

HISTORY OF TRAUMA: please list all accidents, injuries, surgeries, big falls, blows to the head?

- Is there anything else that your therapist should know?

If you are unable to keep your appointment, please notify me at least 24 hours in advance.

SIGNATURE _____ DATE _____

CASE HISTORY FORM

BABIES & CHILDREN (up to 15 years old)

CHILD _____	DATE OF BIRTH D _____ M _____ Y _____
MOTHER'S NAME _____	PHONE (H) _____
FATHER'S NAME _____	(other) _____
ADDRESS _____	
CITY _____	POSTAL CODE _____
EMAIL _____	
DOCTOR'S NAME _____	PHONE _____
Permission to consult with your child's doctor regarding his/her condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	

- Reason for treatment:

- Date of onset:

- Symptoms:

- Has this condition occurred before?

No Yes _____

- Are you taking any medication for any condition?

No Yes _____

- Are you currently seeing another practitioner regarding this condition or your general health?

No Yes _____

HISTORY OF TRAUMA: accidents, injuries, surgeries, big falls, blows to the head?

DENTAL WORK:

GENERAL MEDICAL HISTORY

P = Past C = Current

GENERAL

Feeding Problems _____
Colic _____
Recurrent ear infections _____
Developmental delays _____
Behavioural Problems _____
Hyperactivity/ADD/ADHD _____
Learning disabilities _____
Eye motor problems _____

HEAD & NECK:

Head injury _____
Headaches _____
Migraines _____
Jaw pain / clicking / locking _____
Whiplash _____
Vision Problems _____
Ear/Hearing problems _____
Fainting / Dizziness _____
Ringing in ears _____
Sinus problems _____
Other neurological conditions _____

RESPIRATORY:

Shortness of breath _____
Bronchitis _____
Asthma _____

GASTROINTESTINAL:

Nausea _____
Gas _____
Constipation/Diarrhea _____

CARDIOVASCULAR:

Heart condition _____
High/Low Blood pressure _____
Pacemaker etc. _____
Cardiovascular aneurysm _____

OTHER:

Dislocations _____
Fracture _____
Spinal injury _____
Infections _____
Susceptible to colds/illness _____
Insomnia _____
Fatigue _____
Skin conditions _____
Cancer _____
Epilepsy / Seizures _____
Diabetes _____
Hepatitis _____
Kidney condition _____
Contagious condition _____
Other _____

• Birth Story _____

• Daily Cycles:
Activity level: none/low moderate high
Level of Agitation: none/low moderate severe
Sleep quality: _____
Eating patterns: _____

• Is there anything else that your therapist should know?

If you are unable to keep your appointment, please notify me at least 24 hours in advance.

PARENT'S SIGNATURE _____ DATE _____