



BAYSWATER NEUROMUSCULAR & MASSAGE Confidential Patient Health History Form

NAME: _____

BIRTHDATE: _____ (dd/mm/yyyy)

OCCUPATION: _____

EMAIL: _____

ADDRESS: _____

Postal Code: _____

CELL PHONE: _____

WORK PHONE: _____

HOME LINE: _____

CARE CARD (PHN): _____

Extended Medical Insurer: _____

Policy#: _____

ID#: _____

WHO REFERRED YOU?: _____

YOUR APPOINTMENT TIME is reserved for you. In courtesy of your therapist & fellow patients, a minimum of 24 hours notice is required for any cancellations or the Full Cost of the appointment will be charged. This charge also applies to any "No Shows"/Missed Appointments. Thank you for your co-operation and understanding.

SIGNATURE: _____

DATE: _____ (dd/mm/yyyy)

Known Allergies: (medications, foods, seasonal, oils/lotions, etc) _____

PRESENT SYMPTOMS: What is your major complaint?: _____

When did you first notice the major complaint? _____

What brought it on? _____

What activities aggravate the condition? _____

What have you done to get relief? (Medication, Physio, Chiro, Yoga, etc) _____

Is this condition getting worse? Yes___ No___ Constant___ Comes & Goes___

Is this condition interfering with your Work___ Sleep___ Daily routine___

TURN OVER

Have you had a similar problem before? If Yes, when? _____

Any additional information:

Please "X" or check if applicable

- | | |
|--|--|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Headaches/migraines |
| <input type="checkbox"/> Stroke or Aneurysm | <input type="checkbox"/> Dizziness/Fainting/Loss of balance |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Spinal Injury |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression/Fatigue/Nervousness |
| <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Other Heart Condition | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Epilepsy/other seizures |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Twitching of face |
| <input type="checkbox"/> Other circulatory Condition | <input type="checkbox"/> Other Neurological Condition |
| <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Other Urinary Condition | <input type="checkbox"/> Chronic Sinusitis |
| <input type="checkbox"/> Irritable Bowel/Colitis | <input type="checkbox"/> Chest Pains/Shortness of breath/Tightness in throat |
| <input type="checkbox"/> Digestive Condition | <input type="checkbox"/> Other Respiratory Condition |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Swollen Ankles/Joints |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Disc Problems/Joint Dislocation |
| <input type="checkbox"/> TB | <input type="checkbox"/> Bone Fracture/Osteoporosis |
| <input type="checkbox"/> Other Contagious Condition | <input type="checkbox"/> Rods/Pins/Plates/Shunts/Implants |

BAYSWATER NEUROMUSCULAR & MASSAGE
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