**Mike Fischer RMT**
**Confidential Patient Case History**

**Name:**______________________________________________________________

**Address:** ______________________________________ **Postal Code:** ____________

**Email address:** ________________________________________________________

**How Did You Hear About Our Clinic:** _______________________________________

**Home Phone #:** _____________ **Work #:** _____________ **Cell #:** _____________

**Employer:** _____________________________ **Position:** _______________________

**Male/Female. Birth Date:** ________ **Age:** _____

**# of Children** _____ **Ages of Children** ________________________________________

**Comments - Notes of Caution and Reason for treatment**

______________________________________________________________________

______________________________________________________________________

_____________________________ **Initial Onset:** _________________________
_____________________________ **Probable Cause:** _______________________
_____________________________ **Acute / Chronic**_________________________

**Hobbies, Sports or Recreation:** ______________________________________________

**Have you ever had massage before? YES / NO. Where?** ___________________________

**Date of last treatment:** ____________________________________________________

**Who is your Family Doctor?** ________________________________________________

**Have you been for any of the following treatments in the last 12 months?**
**ChiropracticYES / NO Who?** ________________________________________________

**Physiotherapy YES / NO Who?** ______________________________________________
**Conditioning Therapy YES / NO Acupuncture YES / NO**
**1. Have you had any serious falls, motor vehicle accidents, surgeries or injuries?**
**YES / NO**
**Explain and include dates:** ________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
**4. Is your Blood Pressure: Normal - High - Low - Stable - Erratic**
______________________________________________________________________

**5. Have you ever been *treated for*? *If YES, please explain***

**any psychological or emotional health issues YES______________________________/ NO**
***thyroid problems* YES ______________________________/ NO**
***ulcers* YES ______________________________/ NO**
***heart disease* YES ______________________________/ NO**
***lung disease* YES______________________________/ NO**
***cancer* YES______________________________/ NO**
***diabetes* YES______________________________/ NO**
***HIV / Immune Deficiency* YES______________________________/ NO**
***arthritis* YES______________________________/ NO**
***fibromyalgia* YES ______________________________/ NO**
***liver disorder / hepatitis* YES______________________________/ NO**
***blood clots / varicose veins* YES ______________________________/ NO**
***TMJ* YES______________________________/ NO**
***dizziness* YES ______________________________/ NO**

***other medical conditions or concerns:* ______________________________**

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**7. Please circle:**
***Sleep:* How many hours per night None 1 – 3 3 – 5 5 – 10 More**
***Exercise:* How many hours per week None 1 – 3 3 – 5 5 – 10 More**
***Water Consumption:* How many glasses per day None 1 – 3 3 – 5 5 – 10 More**
***Coffee:* How many cups per day None 1 – 3 3 – 5 5 – 10 More**
***Alcohol:* How many drinks per week None 1 – 3 3 – 5 5 – 10 More**
***Smoking:* How many packs per day None > 1/2 pkg 1/2 pkg full pkg More**

**Headache and Migraine History:**
**Do you get? (please circle) Headaches / Migraines / Both**

**How often do you get them? ______________________________**

**How long do they last? ______________________________**

**What causes your headaches? ______________________________**

**What do you take to control them? ______________________________**
**Current Medications**

______________________________

**CANCELLATION POLICY**

I understand that I must give 24 hours notice when canceling an appointment or will be charged in full if the appointment is not filled. By my signature below, I authorize the collection, use and disclosure of personal information, as defined in the *Personal Information and Protection Act* (PIPA), required for treatment and/or any related administrative purpose. I understand that all my personal information is confidential, and must be treated in accordance with PIPA.

Signature:______________________________Date:______________________________