Patient Case History

(Please print)

Last Name:_____ **First Name:**_____ **Home Phone:** _____

Address:_____ **City/Town:**_____ **Postal Code:** _____

Date of Birth (day/month/year)_____ **Occupation:**_____ **Cell Number:** _____

Employer:_____ **Doctor:** _____

By who were you referred?_____ **Chiropractor:** _____

Email: _____ **(only for appointment reminders, no junk mails will be sent)**

Main Complaint: _____ **Other Complaints:** _____

Type of Pain: (sharp, dull, aching, burning, etc>)

Pain Scale

1 2 3 4 5 6 7 8 9 10

MILD ***STRONG*** ***SEVERE***

Does it radiate?_____ **Where?** _____

What tends to relieve the pain/condition? _____

What tends to aggravate the pain/condition? _____

_____

Any previous injuries (car, sports, falls)? _____

_____

Are you on any medication? YES/NO if yes, what type? _____

Any surgery? _____

Any skin conditions? (acne, scratches, boils, open wounds, planter warts) If yes, list all areas _____

Check the following if applicable to you:

___Allergies _____
___Arthritis
___High/Low Blood Press.
___Cancer
___Constipation
___Diabetes
___Pins,Plates,Prothesis
What:_____
Where: _____
___Blood Disorder

___Dizziness
___Epilepsy
___Fainting
___Hardening of arteries
___Headaches
___Heart Disease
___Hemophilia
___Hernia
___Ulcers
___Other (please specify) _____

___Lung/Respiratory
___Painful Menstruation
___Pregnant (what term?)
___Pain or Stiffness;
Where:_____
___Stroke
___Insomnia
___Hypoglycemia
___Varicose Veins

Have you received Massage Therapy? __Yes __ No

Please read the following and sign below:

Payment is expected at the time service is rendered**. If cancellation is necessary, please give 24 hours notice**, otherwise you will be charged for the appointment. Emergency cancellations are determined at the therapist's discretion.

I give my consent for treatment and I'm aware results are not guaranteed. I have honestly stated all medical conditions and my information is confidential. I agree to inform the therapist if I experience discomfort. I also agree to stop the session if I feel my well-being is compromised in any way.

All patient case history forms remain property of Meridian Integrated Health and Wellness, and can only be released with a signed written request from patient.

Print Name: _____

Date: _____ **Signature:** _____

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