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THERAPEUTICS

GENERAL HEALTH HISTORY QUESTIONNAIRE

☐ **ACUPUNCTURE** ☐ **# ( )2 / 0 2 ! #4)#** ☐ **MASSAGE THERAPY** ☐ **PHYSIOTHERAPY**

Name: _____ **Birth Date**: _____ (MM/DD/YYYY)
Address: _____ **Occupation:** _____
City: _____ **Employer:** _____
Postal Code: _____ **Family Doctor:** _____
Phone: (Home): _____ **Phone:** _____
(Cell): _____ **Emergency Contact Name:** _____
(Work): _____ **Phone/ Relationship:** _____/_____
E-mail Address: _____ **Care Card Number:** _____

How did you hear about us?
☐ Co-Worker ☐ Friend ☐ Family ☐ Internet ☐ Neighborhood ☐ Other

Previous Patient of _____ - Other _____
Do you wish to receive appointment reminders via: ○ Text ○ Email ○ Both?
☐ I agree to grant Royal Treatment Therapeutics permission to send email messages. I understand I may unsubscribe at any time.

Are you coming in today regarding an **ICBC** claim? ○ YES ○ NO
Date of Injury: _____ **Claim #:** _____
Adjuster/Case Manager: _____ **Phone:** _____
Lawyer Name: _____ **Phone:** _____

Have you had previous Chiropractic, Massage Therapy or Physiotherapy? ○ YES ○ NO
When? _____ Where? _____ How many visits? _____

What is the **PRIMARY REASON** for your visit today? _____
_____

When did you **FIRST NOTICE** any symptoms? _____
Have you experienced these symptoms before? _____
Has your condition been getting: ○ Worse ○ Same ○ Better
Are your symptoms: ○ Constant ○ Intermittent
What is your current stress level? ○ Low ○ Moderate ○ High
Is your present condition the result of a single ***traumatic event***? ○ YES ○ NO
If ***YES***, please specify: _____
What other type of treatment, if any, have you received for this condition? Did it help?
_____

Please list all medications (name, dosage) you are currently taking including vitamins and supplements:
_____
_____

Any known allergies? _____

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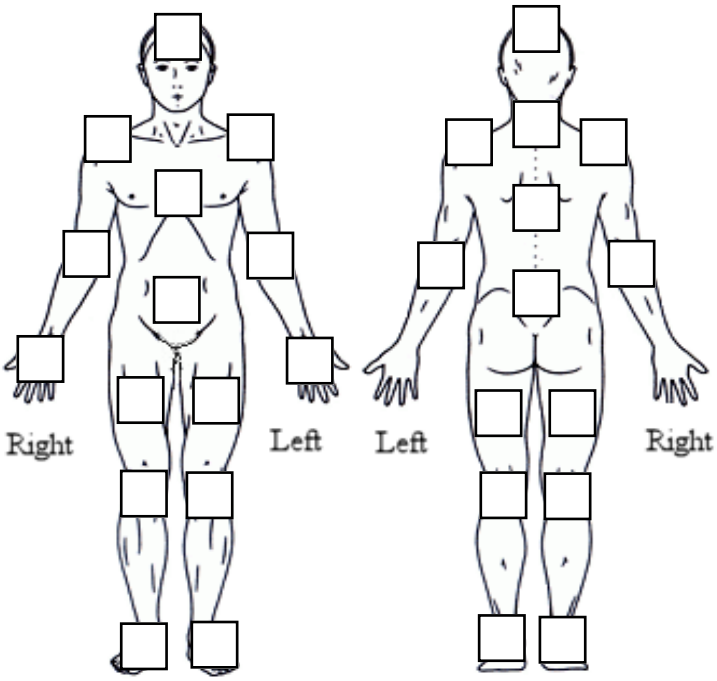
What are your goals to be achieved by the end of treatment?

_____

CHECKMARK THE AREAS OF PAIN ON THE BODY USING THE DIAGRAMS TO THE RIGHT.



NOTE: Please mention any other symptoms during the initial examination.

Indicate your level of pain using a scale of 0-10 (where 0 indicates no pain and 10 indicates excruciating pain):

AT BEST: _____ **AT WORST:** _____

1. What increases/ makes your condition worse? (MARK ALL THAT APPLY)

☐ Bending	☐ Movement	☐ Rest	☐ Better in AM
☐ Sitting	☐ Standing	☐ Heat	☐ Better as day progresses
☐ Rising	☐ Walking	☐ Ice	☐ Better in PM
☐ Lying	☐ Medication	☐ Changing Position	☐ N/A just removed

2. What decreases/ makes your condition better? (MARK ALL THAT APPLY)

☐ Bending	☐ Movement	☐ Rest	☐ Better in AM
☐ Sitting	☐ Standing	☐ Heat	☐ Better as day progresses
☐ Rising	☐ Walking	☐ Ice	☐ Better in PM
☐ Lying	☐ Medication	☐ Changing Position	☐ N/A just removed

3. Previous Medical Intervention (MARK ALL THAT APPLY)

☐ X-RAY ☐ CT SCAN ☐ INJECTIONS ☐ OTHER: _____

4. If there is any other information regarding your present condition that you think would help us, please describe:

_____

_____

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Medical History:

Has anyone in your immediate family been diagnosed with any of the follow? (Check ALL that apply):

- ☐ Cancer
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Stroke
- ☐ Thyroid Issues
- ☐ High Blood Pressure
- ☐ Heart Problems
- ☐ Depression

Have you RECENTLY noticed any of the following? (Check ALL that apply):

- ☐ Fatigue
- ☐ Numbness/ Tingling
- ☐ Diarrhea
- ☐ Fever/Chills/Sweats
- ☐ Muscle Weakness
- ☐ Shortness of Breath
- ☐ Nausea/Vomiting
- ☐ Dizziness/Light Headed
- ☐ Double Vision
- ☐ Fainting
- ☐ Weight Gain/Loss
- ☐ Heartburn/Indigestion
- ☐ Cough
- ☐ Falls
- ☐ Difficulty Swallowing
- ☐ Headaches
- ☐ Constipation
- ☐ Difficulty in Eating/Speaking
- ☐ Night Pain
- ☐ Changes in Bowel/Bladder Function

Have you EVER been diagnosed with any of the following conditions? (Check ALL that apply):

- ☐ Difficulty Swallowing
- ☐ Motion Sickness
- ☐ Stroke
- ☐ Arthritis
- ☐ Fever/Chills/ Sweats
- ☐ Osteoporosis
- ☐ High Blood Pressure
- ☐ Unexplained Weight Loss
- ☐ Anemia
- ☐ Heart Trouble
- ☐ Blood Clots
- ☐ Bleeding Problems
- ☐ Pacemaker
- ☐ Shortness Of Breathe
- ☐ HIV/Hepatitis
- ☐ Epilepsy/ Seizures
- ☐ History Of Smoking
- ☐ History Of Alcohol Abuse
- ☐ History Of Drug Abuse
- ☐ Diabetes
- ☐ Depression/ Anxiety
- ☐ Myofascial Pain
- ☐ Fibromyalgia
- ☐ Pregnancy

Are you pregnant or planning to get pregnant? ◯ YES ◯ NO
Do you have any orthopaedic (metal) implants in your body? If yes, where? _____
Do you have a cardiac pacemaker? ◯ YES ◯ NO
Have you ever had any broken bones? If yes, which ones? _____
Have you ever had any surgery? If yes, please describe: _____
_____

Cancelation Policy:

In consideration of other patients and my therapist, I understand that a minimum of **48 hours'** notice is required to change or cancel my appointment**. I am aware that it is my responsibility to pay 100% of the treatment fee in the case of late cancellations or missed appointments.** By signing below you understand and agree to our cancellation policy.

Consent for Treatment:

I also confirm the health and medical information given above to be accurate. I understand the therapeutic benefits and possible side-effects of the treatment that may be recommended for my condition and for any future conditions for which I seek treatment, and I consent to the proposed treatment.

Signature: _____ **Date:** _____ (MM/DD/YYYY)