Cathedral
SPORTS MASSAGE

PATIENT HISTORY

Name:____ Date: ____________________

Address: ____ Birthday: ________________

Postal Code: ___________________

Phone: H:_____________________ W:____________________ C:_____________________

Email: ____________________________________

Occupation: ___________________________________

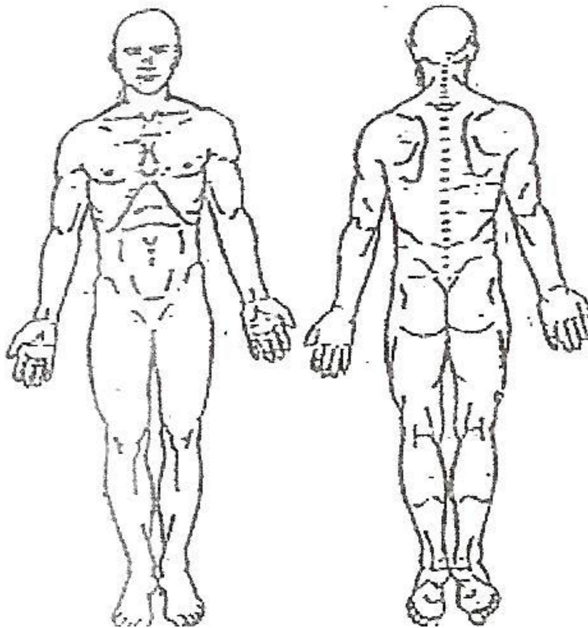
Physician: _____________________________________ Phone: __________________

Address: ____________________________________

SGI ( ) WCB ( ) Adjuster: _____________________________ Claim #: _________________

Whom may we thank for referring you to our clinic? ___________________________________

Please describe your present complaint and shade in areas of pain/discomfort on the diagram:



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Rate your pain 1 being no pain at all and 10 being the worst possible:

1… 2… 3… 4… 5… 6… 7… 8… 9… 10

List previous injuries, accidents, or surgeries with their dates or year:

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Have you received treatments from any of the following providers?

[ ] Physician [ ] Chiropractor [ ] Physiotherapist [ ] Massage Therapist [ ] Acupuncturist

Name of Provider: ________________________ Name of Provider: ______________________

Reason for treatment: _____________________ Reason for treatment: __________________

Results: __________________________________ Results: _______________________________

OVER >>>>

Have you been diagnosed or treated by a physician for any of the following medical conditions?

[] Allergies	[] High [] Low Blood Pressure	[] Respiratory Conditions
[] Arthritis	[] Heart Conditions	[] Neurological Conditions
[] Cancer	[] TMJ	[] Whiplash
[] Cholesterol	[] Headaches	[] Skin Conditions
[] Diabetes	[] HIV	[] Varicose Veins
[] Digestive Disorders	[] Hepatitis	

[] other: ____

Does your immediate family have any of the following conditions?

[] Back Pain	[]High [] Low Blood pressure	[] Cancer
[] Heart Disorders	[] Arm/Shoulder Pain	[] Respiratory Conditions
[] Headaches	[] Arthritis	[] Neurological Conditions
[] Digestive Disorders	[] Diabetes	

Are you presently taking any prescription medication?

Name:	Reason:	Duration:
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________

Are you presently taking any non-prescription medication?

[] No [] Yes If yes, list:____

The information contained on this form is true and complete to the best of my knowledge.

______________________________ ______________________

Signature of Patient/Guardian Date Signed

AUTHORIZATION

This is your full and sufficient authority to release any and all medical/health records/information concerning myself to your:

Physician: ______________________________ at ____________________

Chiropractor: ______________________________ at ____________________

Physiotherapist: ______________________________ at ____________________

Insurance Company/Adjustor ____________________ at ____________________

Dated at Regina, Saskatchewan this _____ day of __________________, _________.

Signature: ______________________________

OVER >>>>