Mountainview Chiropractic & Massage Therapy

Unit #104 - 6543 Portsmouth Road
Nanaimo, BC V9V 1A3 (250) 933-3443
mountainviewchiropractic@shaw.ca

CONFIDENTIAL PATIENT HISTORY

Name: ______________________ **BC Health Card #:** ______________________

Date of Birth: ______________________ **Gender: F M**

Phone #: ______________ **Work #:** ______________ **Cell #:** ______________

Address: ______________________________ **Postal Code:** ______________

Occupation: ______________________ **Family Doctor:** ______________________

Chief Complaint:
What is the reason you are seeking treatment? ______________________

Is this condition any of the following claims:
Please note we do not treat any WSBC claims for massage therapy

☐ RCMP # ______________________ ☐ VAC # ______________________

☐ ICBC #______________________ Date of MVA: ______________________

Other Health Care Providers

☐ Other Registered Massage Therapist ______________________

☐ Physiotherapist ______________________ ☐ Chiropractor ______________________

☐ Acupuncturist ______________________ ☐ Osteopath ______________________

☐ Kinesiologist ______________________ ☐ Personal Trainer ______________________

Areas of Complaint (Please provide details)

☐ Head/Neck ______________________ ☐ Abdominal ______________________

☐ Shoulder(s) ______________________ ☐ Arms ______________________

☐ Chest ______________________ ☐ Hips/Gluteals ______________________

☐ Upper Back ______________________ ☐ Leg(s) ______________________

☐ Mid Back ______________________ ☐ Feet ______________________

☐ Low Back ______________________

Type of pain

☐ Aching ☐ Burning ☐ Stabbing ☐ Throbbing ☐ Shooting

What aggravates the pain? ______________________

What relieves the pain? ______________________

Medical History

☐ Tension Headaches ☐ Neck Tension/Pain ☐ Earaches/Pain

☐ Migraines ☐ Jaw/TMJ Problems ☐ Tinnitus/Ringing in Ears

Musculoskeletal: (Please provide details)

☐ Artificial joints, internal pins, wires or plates ______

☐ Disc Herniation ______ ☐ Fractures/Broken Bones ______

☐ Whiplash ______ ☐ Dislocation ______

☐ Arthritis (please specify type)______ ☐ Strains/Sprains ______

☐ Osteoporosis/Osteopenia ______ ☐ Tendinitis ______

☐ Fibromyalgia ______ ☐ Bursitis ______

☐ Frozen Shoulder ______ ☐ Plantar Fasciitis ______

Cardiovascular (check all that apply)

☐ High Blood Pressure ☐ Heart Attack ☐ Aneurysm/Stroke ☐ Heart Disease

☐ Low Blood Pressure ☐ Chest Pain ☐ Phlebitis/Varicose Veins ☐ Congestive Heart Failure

Respiratory (check all that apply)

☐ Asthma ☐ Chronic Cough ☐ Shortness of Breath

☐ Bronchitis ☐ Emphysema ☐ Smoking

Neurological (check all that apply)

☐ Sciatica ☐ Epilepsy/Seizures ☐ Anxiety ☐ PTSD

☐ Numbness/Tingling ☐ Brain Injury ☐ Depression ☐ Emotional Stress

☐ Dizziness ☐ Insomnia

Gastrointestinal/Urological (check all that apply)

☐ Heartburn/Reflux ☐ Constipation ☐ Ulcerative Colitis ☐ Kidney/Bladder Problem

☐ Difficult digestion ☐ Diarrhea ☐ Crohn’s Disease ☐ Liver/Gall Problems

☐ Ulcer ☐ IBS

Infections (check all that apply)

☐ Hepatitis ☐ Herpes ☐ Skin

☐ TB ☐ HIV ☐ Other ______

Women

☐ Menstrual Problems ☐ Polycystic Ovary Syndrome (PCOS) ☐ Menopause Symptoms

☐ Pregnant (Please indicate due date) ______

Other Conditions

☐ Diabetes (onset/type) ________________________ ☐ Allergies/Hypersensitivities _____________________

☐ Skin Conditions ____________________________ ☐ Cancer __________________________________

☐ Other ____

Additional Information

☐ Current Medications	☐ Surgeries	☐ Injuries/Accidents
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Activities & Exercise

What activities, sports or exercise do you do? ____

____

How did you hear about this clinic? ____

Appointment reminder options:

☐ I would like appointment reminders by email (48 hr before). E-mail address _________________________

☐ I would like a text reminder for appointments (24 hr before). Cell #: _____________________________

☐ I would like a phone call reminder for appointments (business day before appointment).

☐ Mountainview Chiropractic & Massage Therapy can directly bill some extended healthcare insurers for treatments. I give consent for this clinic to submit the claim on my behalf and receive the assigned payment. Any uninsured portion is my responsibility.

☐ I authorize the practitioners at Mountainview Chiropractic & Massage Therapy to share my health records amongst themselves in order to more effectively manage my health concerns and gain insight from the different health care providers within the clinic. *Consent is optional*.

☐ I understand my appointment time is reserved especially for me and that if I must cancel or reschedule an appointment, **a minimum of 24 hours** notice is required, otherwise, I agree to pay the therapist the **FULL** fee for the missed appointment.

Name (please print) ____

Signature: ____ Date: _______________________