CONFIDENTIAL PATIENT HEALTH HISTORY

Name: ______________________________

Address: ______________________________

______________ City: ______________

Postal Code: ______________ Phone Number: ______________

Email: ______________ Date of Birth: ______________

Gender: M/F Occupation: ______________

Doctor: ______________ PHN: ______________

Is this an ICBC or WCB Claim? ________ Claim #: ______________

How did you hear about Limestone? ______________________________

Please indicate if any of the following apply to you. P=Past C=Current

- [ ] Heart Attack
- [ ] High/Low Blood Pressure
- [ ] Stroke/Aneurysm
- [ ] Pace Maker
- [ ] Other Heart Condition

- [ ] Varicose Veins
- [ ] Bruise Easily
- [ ] Other Circulatory Conditions

- [ ] Diabetes
- [ ] Kidney Disease
- [ ] Irritable Bowel/Colitis
- [ ] Digestive Conditions
- [ ] Other Urinary/Bowel Conditions

- [ ] Headaches/Migraines
- [ ] Dizziness/Fainting
- [ ] Nausea
- [ ] Spinal Injury/Surgery
- [ ] Head Injury
- [ ] Epilepsy/Seizures
- [ ] Other Neurological Conditions

- [ ] Asthma
- [ ] Chronic Sinusitis
- [ ] Emphysema
- [ ] Other Respiratory Conditions

- [ ] Skin Conditions
- [ ] Eczema

- [ ] Dislocations
- [ ] Fractures
- [ ] Arthritis Osteo/Rheumatoid
- [ ] Osteoporosis
- [ ] Rods/Pins/Plates Etc.
- [ ] Implants
- [ ] Transplants

- [ ] Cancer
- [ ] Hepatitis
- [ ] HIV
- [ ] Other Contagious Conditions

Medications: ______________________________

____

Allergies: ______________________________

____

Have you ever been in a car accident? When? ______________________________

Have you ever had any surgeries? If so, please explain? ______________________________

____

Other therapies you have tried? ______________________________

Current Condition

Please describe your current condition: ______________________________

____

____

____

How long have you had this condition? ______________________________

Is it any better now than when it began? ______________________________

How did your condition start? ______________________________

____

What makes it better? ______________________________

What makes it worse? ______________________________

Please mark your pain level as of right now with an x and the worst it has been with an O:

Pain Scale Definitions

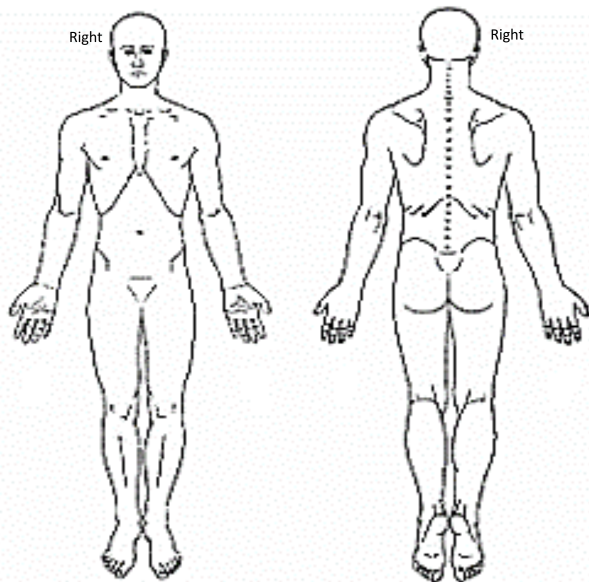
10: Pain that makes me go unconscious
9: Take me to the hospital
8: Intense pain. Cannot accomplish anything due to the pain
7: Considerable pain. Can no longer work through it
6: Strong pain. Difficult to work through, but still can with effort
5: Strong pain but can still go to work
4: Noticible pain. Think about it much of the day
3: Noticible pain but I can tolerate it.
2: Uncomfortable
1: Light pain. Barely noticible most of the time
0: No pain

Please mark the diagram with the areas of your pain:

0 = sharp

^ = burning

/ = tingling



Please Note: Your appointment time has been reserved for you. In courtesy of your therapist and fellow patients, we ask that you provide us with 24 hours of cancellation, or you will be charged for your appointment time. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

I authorize the clinic and its associated RMTs to collect my personal and medical information as documented above in order to contact me through phone, text or email and I give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided.

I authorize the clinic and its associated RMTs to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my persmission.

Signature: ______________________________ Date: ______________________