CONFIDENTIAL MEDICAL CASE HISTORY FORM

Name: ____

Phone #: (home) ______________ (work or cell) ________________ **Phone number for Messages:** _______________

Care Card #: ___________________ **Birth Date:** (m)___ (d)___ (y)_____ G_1 V_2

Address:____ **Postal Code:**___________________

May the clinic contact you by mail? Yes ☐ No ☐

Occupation:_________________________ **Referring Doctor:** ___________________ **Billing #:**__________

How did you hear about our clinic? _______________________________________

ICBC or WCB Claim: Yes ☐ No ☐ **Claim #:**____________________ **Date of Accident:** _____________________

Adjuster's Name: ______________________________ **Phone #:**_____________________________

Adjuster's Address: _____________________________ **Fax #:** ______________________________

Lawyer's Name: ________________________________ **Phone #:**_____________________________

Major Complaint:____

What makes condition worse? ________________________ **better?** ______________________________

Have you had this condition in the past? ☐ Yes ☐ No. **If yes, was it resolved?** ☐ Yes ☐ No

Medications you are presently taking: ____

Surgeries, major injuries or accidents you have had: ____

Stress level: ☐ None ☐ Slight ☐ Moderate ☐ Severe **Physical activity:** ☐ None ☐ Low ☐ Moderate ☐ High.

Are you also seeing: ☐ Chiropractor ☐ Physiotherapist ☐ Naturopath Other ___________________________

Please check any of the following conditions that apply to you:

☐ Heart Condition
☐ Stroke (CVA)
☐ High/Low Blood Pressure
☐ Respiratory Conditions
☐ Cancer
☐ Tumours/Cysts
☐ Diabetes
☐ Varicose Veins

☐ Osteo/Rheumatoid Arthritis
☐ Fibromyalgia
☐ Spinal Injury
☐ Loss of Sensation/Tingling
☐ Seizures
☐ Dizziness
☐ Digestive Disorder
☐ Pregnancy

☐ Fractures/Dislocations
☐ Menstrual Problems
☐ Skin Condition
☐ Contagious Condition
☐ Headaches (recurrent)
☐ Backaches
☐ Other ___________________
____

Your time is valuable, and so is ours. Please understand that your appointment time is reserved for you. We cannot make a living if you cancel your appointment on the same day, or worse, do not come at all. Please acknowledge this by signing the agreement below. Please note that and we **cannot bill** MSP or ICBC for missed appointments.

I understand that I will be charged **a cancellation fee** of $25 if I do not give **24 hours** notice of a change or cancellation of appointment.

By my signature below, I authorize the collection, use and disclosure of personal information, as defined in the *Personal Information and Protection Act* (PIPA), required for treatment and/or any related administrative purpose. I understand that all my personal information is confidential, and must be treated in accordance with PIPA.

Signature: ___________________________________ Date: ____________________________