CLIENT CASE HISTORY FORM

NAME _____ PHONE # Home (___)_____

ADDRESS _____ Work (___)_____

CITY _____ POSTAL CODE _____ BIRTHDATE _____

OCCUPATION _____

Email address _____

Are you currently under the care of a doctor or other health care provider?_____

☐ Family Doctor _____ ☐ Naturopathic Doctor _____

☐ Chiropractor _____ ☐ Physiotherapist _____

HEALTH HISTORY

☐ Herpes	☐ Joint stiffness	☐ Asthma
☐ Warts	☐ Joint swelling	☐ Chronic cough
☐ Athletes foot	☐ Strains	☐ Shortness of breath
☐ Other skin disorders	☐ Sprains	☐ Smoking
☐ High blood pressure	☐ Ulcers	☐ Headaches
☐ Low blood pressure	☐ Bowel disorders	☐ Migraines
☐ Heart disease	☐ Liver disease	☐ Diabetes
☐ Poor circulation	☐ Kidney disease	☐ Dizziness
☐ Varicose veins	☐ Cancer	☐ Allergies

PLEASE INDICATE ANY AREAS OF PAIN OR TENDERNESS:

☐ Head	☐ Neck	☐ Chest
☐ Shoulders (Rt Lt)	☐ Arms (Rt Lt)	☐ Hands (Rt Lt)
☐ Upper back	☐ Mid Back	☐ Lower Back
☐ Hips (Rt Lt)	☐ Tail bone	☐ Thighs (Rt Lt)
☐ Abdomen	☐ Knees (Rt Lt)	☐ Feet (Rt Lt)

Major complaint(s):_____

_____

List any surgery (include dates): _____

_____

_____

List any major injuries: _____

_____

_____

List present medication and/or supplements _____

_____

_____

What types of treatment are you presently involved in?

_____

Are you pregnant? (circle) YES NO POSSIBLY

Any other concerns not mentioned (scars):

_____

_____

Is there any history of family disease?_____

_____

I, _____ release the practitioner Alandra Shaffer from all liability from problems arising from the treatment as a result of information not given or incorrectly given in the case history.

Signature_____ Date:_____