KOI TREATMENT CENTRE CONFIDENTIAL HEALTH HISTORY **FILE # _____**

Name: _____ Birth Date: _____
First Middle Last M/D/Y

Address: _____ Care Card #: _____
Postal Code: _____
Telephone: (H)_____ ICBC/WCB# _____
W)_____ Cell)_____ Adjuster's Name: _____
Occupation: _____ Telephone: _____
Referring Physician_____
Areas Referred (Office Use)_____

Office Use Only

PLEASE CHECK {√ } THE CONDITION YOU EXPERIENCE TO HELP WITH YOUR TREATMENT.

[ ] Headaches, type: _____
[ ] Limitations of Movement, where:_____
[ ] Pain: where:_____

[ ] stiffness	[ ] cancer	
[ ] swelling	[ ] allergies	
[ ] high blood pressure	[ ] pregnant	
[ ] phlebitis	[ ] arthritis	
[ ] varicose veins	[ ] shortness of breath	[ ] fatigue []osteoporosis
[ ] heart disease	[ ] bruise easily	[ ] dizziness
[ ] chronic cough	[ ] diabetes	[ ] menstrual pain
[ ] constipation	[ ] contagious skin condition	[ ] altered sensation (tingling, numbness)

How does this interfere with your daily routines? (i.e. work, sleep etc.) _____
_____
Surgery/injury: _____ Date: _____
Type: _____
Current Symptoms: _____
Current Medications and Conditions Treated: _____
_____
Other medical conditions:_____

Are you currently seeing any of the following practitioners for care related to this condition?
[ ] chiropractor [ ] physiotherapist [ ] occupational therapist [ ] kinesiologist [ ] other

Have you had previous massage therapy care? [ ] yes [ ] no
Rate the following on a scale (1= Poor ⇒ 5=Great)
Sleeping Patterns: 1 2 3 4 5 Eating Habits: 1 2 3 4 5 Exercise Habits: 1 2 3 4 5

What is your goal for today's treatment? _____
How did you hear about our clinic? _____
Email Address:_____ Would you like to receive our Newsletter? [ ]Yes [ ]No
I have filled this form to the best of my knowledge, if there are any changes to the above form I will inform the therapist. I consent to be treated.

Signature: _____ Date: _____