BLISSFUL BALANCE
WELLNESS

CONFIDENTIAL CLIENT HISTORY

NAME_____ BIRTH DATE_____

ADDRESS _____ CITY/TOWN_____

POSTAL CODE_____E-MAIL_____

PHONE – (H) _____(W) _____(cell) _____

EMPLOYER _____OCCUPATION_____

Emergency Contact Name_____Phone #_____Relationship_____

Whom may we thank for referring you to our clinic?_____

MEDICAL HISTORY

Is this a claim with SGI ( ) or WCB ( ) or Veteran's Affairs ( ) Claim #_____
Name of injury worker _____ Phone #_____
Date of Injury _____

PHYSICIAN _____PHONE OR ADDRESS_____
Last physical or visit? _____

Are you presently taking any prescription or non-prescription medication, supplements or natural remedies? Please list

NAME	REASON
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any **Allergies?** _____

Are you receiving treatment from any of the following at the present time?
Physician ( ) Chiropractor ( ) Physiotherapist ( ) Naturopath ( ) Acupuncturist ( ) Massage Therapist ( )
Exercise Therapist ( ) Manual Osteopathic Therapist ( ) Other: _____

Exercise & physical activity: ( ) very 5-7 X/week ( ) moderate 3-4 X/ week ( ) light 1-2 X/week ( ) sporadic ( ) none
Work, do you routinely: ( )sit ( )stand ( ) light manual labour ( ) heavy labour ( )combination
Daily water consumption? ( ) light ( ) moderate ( ) heavy
Caffeine? ( ) light ( ) moderate ( ) heavy
How do you sleep? ( ) Well ( ) Variable ( ) Not Well
What is your diet like? ( ) Well Balanced ( ) Variable ( ) Needs Improvement
How are your energy levels? ( ) High Energy ( ) Moderate ( ) Low Energy
Type of activities or hobbies? _____

OVER>>>>>>

Please indicate Current conditions with a C and Previous with a P?

Cardiovascular:
___High/Low Blood Pressure
___Heart Disease/Conditions
___CHF or Heart Attack
___Phlebitis/Thrombosis
___Circulatory Conditions
___Varicose Veins
___Stroke/CVA
___Cold hands/feet
___Swelling in hands/feet
___Poor wound healing
___Pacemaker or other devices

Soft Tissue/Joint/Nerve:
___Fibromyalgia
___Arthritis___RA___OA
___Herniated Disc(s) Level___
___Osteoporosis
___Fracture: Where_____
___Thoracic Outlet Syndrome
___Head Trauma/Concussion
___Whiplash/Car Accident
___Neck pain/Stiffness/Injury/Numbness
___Shoulder Pain/Stiffness/Injury
___Arm Pain/Weakness/Numbness
___Back Pain/Stiffness/Injury
___Leg Pain/Weakness/Injury/Numbness
___Knee or Foot Pain/Injury
___Tendonitis/Tenosynovitis
___Bursitis or Dislocation
___Sport/Work Related Injury
___Carpel Tunnel Syndrome

Respiratory:
___Chronic Cough
___Shortness of Breath
___Respiratory Disease
___Bronchitis/Asthmas
___Sinus Infections Emphysema
___Smoke/Vape

Digestive:
___Constipation
___Nausea/Vomiting
___Ulcers/Blood in Stool
___Liver/Kidney Problems
___Rapid Weight Loss/Gain
___Appetite Changes
___Ulcerated Colitis/Crohn's/IBS

Head and Neck:
___Tension/Migraine Headaches
___Tinnitus (ringing in ears)
___Tooth/Jaw/Ear Pain
___Vision Problems/Loss
___Hearing Loss
___Dizziness/Vertigo/Lightheaded
___Other:_____

Women:
___Painful Menstruation
___Pelvic Inflammatory Disorder
___Hysterectomy
___Birth Control
___C-section
___Pregnant – Due: _____

Skin:
___Bruise easily
___Rash/Open sores/Warts
___Sensitivity/skin allergies:_____
___Contagious skin disease
___Shingles

Urinary:
___Chronic Infections
___Blood in Urine

Endocrine:
___Thyroid Problems
Type:_____

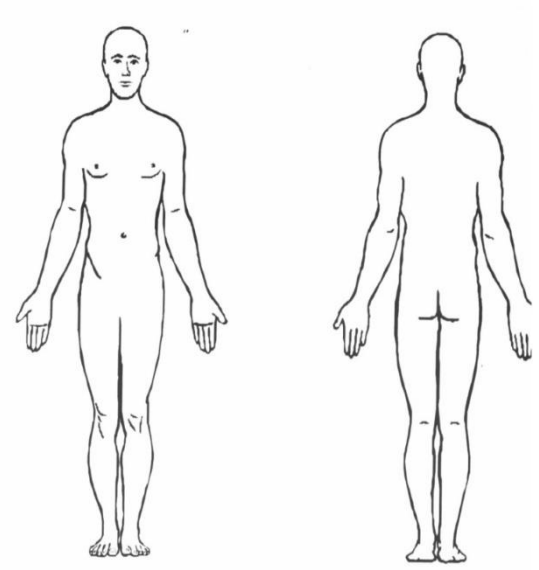
Infections:
___Hepatitis
___Tuberculosis
___HIV

Other Conditions:
___Loss of Sensation
___Diabetes – Onset/Type:_____
___Epilepsy
___Insomnia
___Depression/Anxiety
___Multiple Sclerosis
___Cancer – Onset/Type:_____
___Substance Dependency
Other: _____

REASON FOR VISIT Therapy?_____Relaxation?_____
Please describe your present complaint:
_____
_____
_____
_____
_____
_____
Initial onset of pain?_____
Is the pain ( )local ( )radiating ( ) throbbing ( ) dull
( ) stabbing ( ) pins & needles ( ) numbness ( ) burning
( ) intermittent ( ) constant
Is the pain ( ) less ( ) worse later in the day or
( ) less ( ) worse on waking?

Have you had any surgeries in the past? Y/N
Please explain _____
_____
Have you ever had any fractures? Do you have any pins, plates, or joint replacements? or any other notes of caution_____

Shade in areas of concern on the diagram:



_____ _____ _____
Print Name Signature of patient Date