Patient Case History (Please print)

Last Name:	First Name:	Home Phone:
Address:	City/Town:	Postal Code:
Date of Birth (day/month/year)	Occupation:	Cell Number:
Employer:	Doctor:	
By who were you referred?Chiropractor:		
Email: (only for appointment reminders, no junk mails will be sent)		
Main Complaint:	Other Complaints:	
Type of Pain: (sharp, dull, aching, burning, etc>)		
1 2 MILD Does it radiate? Where?	STRONG	8 9 10 SEVERE
What tends to relieve the pain/condition?		
What tends to aggravate the pain/condition?		
Any previous injuries (car, sports, falls)?		
Are you on any medication? YES/NO if yes, what type?		
Any surgery?		
Any skin conditions? (acne, scratches, boils, open wounds, planter warts) If yes, list all areas		
Check the following if applicable to youAllergies	Dizziness Epilepsy Fainting Hardening of arteries	Lung/RespiratoryPainful MenstruationPregnant (what term?)Pain or Stiffness; Where:StrokeInsomniaHypoglycemiaVaricose Veins
Have you received Massage Therapy?Yes No		
Please read the following and sign below: Payment is expected at the time service is rendered. If cancellation is necessary, please give 24 hours notice, otherwise you will be charged for the appointment. Emergency cancellations are determined at the therapist's discretion. I give my consent for treatment and I'm aware results are not guaranteed. I have honestly stated all medical conditions and my		
information is confidential. I agree to inform the therapist if I experience discomfort. I also agree to stop the session if I feel my well-being is compromised in any way.		
All patient case history forms remain property of Meridian Integrated Health and Wellness, and can only be released with a signed written request from patient.		
Print Name:		
Date:	Signature:	