

Confidential Patient History

Name: _____

Date of Birth: ____/____/____
(Month/Day/Year)

Address: _____

City Postal Code

Care Card # _____

Phone: (Home) _____

(Work) _____

(Cell) _____

E-mail: _____

Occupation: _____

(Only if Applicable)
ICBC Claim # _____
Date of MVA: _____
ICBC Contact: _____
Claim Center: _____

How did you hear about this clinic? _____

Please list all medications you are currently taking: _____

Known Allergies (medications, foods, seasonal, etc.) _____

Please list any illnesses, surgeries, major accidents, conditions that you have had: _____

Please complete the following: (P = Past C = Current)

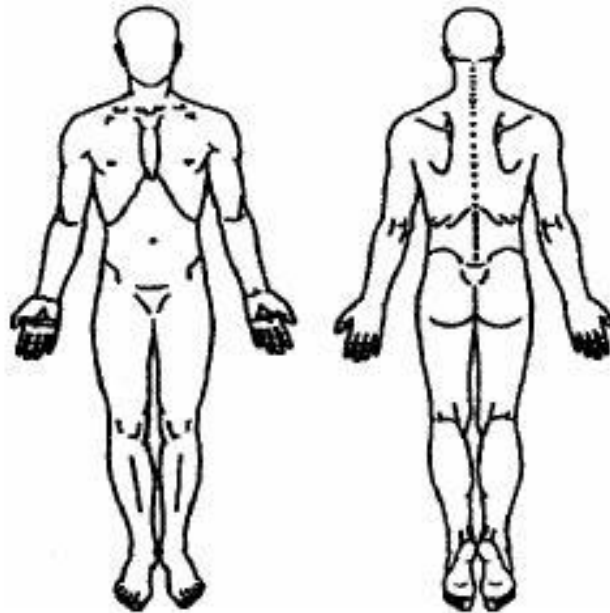
- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Joint Dislocation | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Bone Fracture | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Spinal Injury | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Neurological Condition | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Circulatory Condition | <input type="checkbox"/> Respiratory Condition | <input type="checkbox"/> Skin Condition | |

Please describe your current pain and symptoms: _____

How long have you had these symptoms? _____

How did it start? _____

Please indicate the areas where you experience your pain/symptoms by marking the diagrams with a "X".



Please Note: Your appointment time has been reserved for you. In courtesy of your therapist and fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a \$50.00 cancellation fee will be charged. Payment for all treatment is ultimately the responsibility of the patient.

Signature: _____

Date: _____