NAME: ________________________________ **DATE OF BIRTH:** ________________________

PHONE (home):

____

Family Doctor: __________________________

BC Care Card#: __________________________

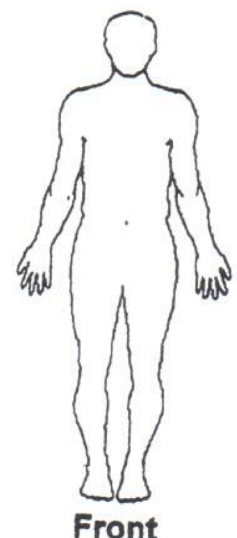
PHONE (work/cell):

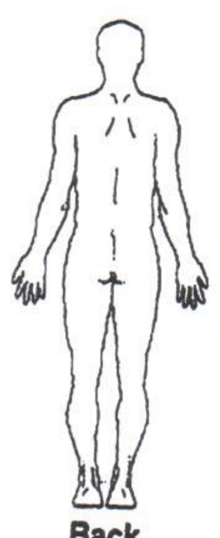
____

Email: __________________________________

MEDICAL HISTORY: ***Do any of the following conditions apply?***

	YES	NO
Heart problems……………………….		
Pregnancy or possibility of…………		
Plastic or metal replacements…….		
Recent surgeries……………………….		
Medications…………………………….		
Ever treated for cancer………………		
Any other major health problems…		





If yes, explain:

____

____

Please circle area(s) of injury on diagram above.

Have you received physiotherapy this year? _____ If yes, how many visits? ________ Where were you treated? ____________________ ____	How were you referred to this clinic? Doctor's referral? __________ Advertising? What form? ____________ Other? ___________________________

The above information is correct to the best of my knowledge.

Signature: ____

Date: ____