Todays Date: ___________________

Name:____________________________________

Birthdate:__________________________________ Care Card #: ______________________________

Address: ____

Phone Number : _______________________ Alternate Phone number: ________________________

Email: ______________________________________ Occupation: ____________________________
(for email reminders)

How did you hear about us? ____

Are you here as a result of a motor vehicle accident? __ Yes __ No
Are you here as a result of a work related injury or accident? __ Yes __ No
Do you have an active claim with ICBC or WCB? __ Yes __ No
Do you have extended health benefits? __ Yes __ No

Please describe your current condition and symptoms: ______________________________________

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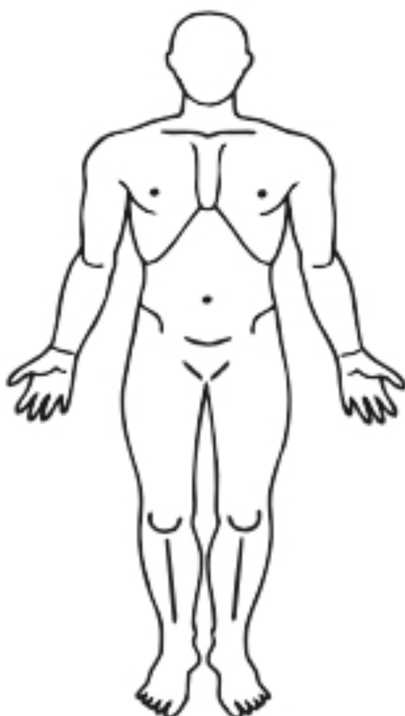

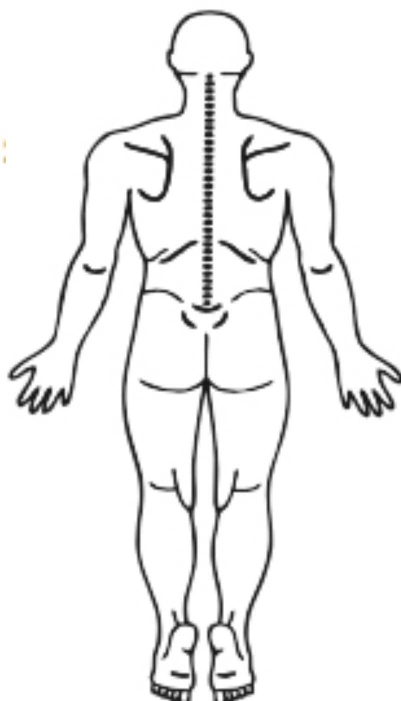

Please mark the areas of injury or discomfort

Aching	O O
Stabbing	X X X
Shooting	→ →
Burning	# # #
Numbness or Tingling	≈ ≈

How long have you had this condition?____

Have you sustained any falls or accidents? ______________________________________

____

Surgeries: ____

Hospitalizations: ____

Do you exercise? __ Yes __ No. How often? ______________________________

What types of exercise do you do: ____

Do you take any medications? __ Yes __ No.

What are the names and reasons for taking the medication? ________________________

____

____

Circle the correct letter for any of the following symptoms you now have, or have had previously:
(C = Current P = Past)

C P	Neck Pain	C P	Hepatitis
C P	Mid Back Pain	C P	Heart Attack
C P	Low Back Pain	C P	Asthma
C P	Stiffness	C P	Seizures
C P	Headaches	C P	High/Low Blood Pressure
C P	Numbness / Tingling	C P	incontinence
C P	Dizziness / fainting	C P	Anxiety
C P	Nausea	C P	Depression
C P	Head injury / Concussion	C P	Tinnitus (ringing in ears)
C P	Spinal injury	C P	Vertigo
C P	Bone fracture	C P	Skin Condition ____________________
C P	Joint dislocation	C P	Digestive Condition ________________
C P	Rods/Pins/Plates/Shunts	C P	Heart or circulatory condition ___________
C P	Arthritis	C P	Other contagious condition ____________
C P	Cancer	C P	(Woman only) Irregular or Painful Menstruation

I affirm that all information on this form is true and correct to the best of my knowledge. I understand that my personal information is confidential and not given out to anyone without written and signed consent. I understand there is a 24hr cancellation policy, and that i may be charged for a last minute cancellation.

_________________________ (Date here) _________________________ (Sign here)