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Last Name: First Name:

Occupation:

Date of Birth: (dd/mm/yyyy) Age:

**Address:**

**City:**   **Province:**   **Postal Code:**

**Phone:** (Home) (Work) (Cell)

**Email** (used only for appt reminders)**:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact: Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Doctor: Referral: YES NO

Specialist: Referral: YES NO

**Please check ONE box for appointment reminder preference:**

**Text message Email Phone call None**

**How did you hear about us:**

**If you have had physio/massage before how did it meet with your expectations:**

**Health Insurance Company/WorkSafe/MVA:**

Are you currently taking any medication? YES NO (If yes, please list below or on reverse)

Are you allergic to latex? YES NO

Do you have any metal implants? (ie. plates or screws in joints) YES NO

Do you have a pacemaker? YES NO

Do you have any of the following:

Cancer (past or present) YES NO Polio (past or present) YES NO

Tuberculosis YES NO Blood Clots YES NO

Circulatory Problems YES NO Epilepsy YES NO

High Blood Pressure YES NO Diabetes YES NO

Osteoporosis YES NO Rheumatoid Arthritis YES NO

Any other medical problems (Please list):

If female, are you pregnant or trying to get pregnant? YES NO

Would you be interested in receiving our monthly HPC e-newsletter? **YES NO**

Patients are responsible for all amounts not covered by insurance. Payment may be made by cash, debit, Visa or Master Card. Payment is due at time of treatment. 2% interest will be added monthly to all accounts over 30 days old.

**We ask that you give us** **24hrs notice if you need to change your appointment. There is a $25 fee for cancellations or re-books not made within this time frame. We also charge $25 for no-shows.**

I consent to be assessed by a physiotherapist/massage therapist and to participate in the treatment plan explained by my physiotherapist or massage therapist.

Signature: Date: