

Confidential Client History Form

101 - 321 Coronation Ave., Duncan, B.C. V9L 2T1 Ph: 250-746-6171

General Information Name:		_ Occupati	ion:		
Address:					
		_	Address:		
Phone:		_			
Cell Phone:		_	Phone:		
Date Of Birth:		-	Emergency co	ontact:	
Personal Health #		_	Phone:		
Extended Health Care Pro	vider:	 -	Referred by:		
Policy #		& I.D.# _			
Email address:		_		=======	
Is there currently a claim Recent motor vehicle acci Work related injury (WCB)	against: dent (ICBC)) Yes	Yes	No		
General Health: Excellent: List any Activities, Sports, Present medications & the	Hobbies:				
Have you ever been involve Past or present injuries, so					
	er back	Arm(s)		Hand(s)	
Thigh(s) Neck Mid Feet	back	Elbow	(s)	Fingers(s)	Knee(s)
	er back	Wrist(s)	Hip(s)	Leg(s)
Chest Ribs	5	Tail	bone		
Please check off any of th Allergies Skin pro	Diabe	•	C- Current, P -	Past Inflamma	ation
Aching joints Stroke	Dizzir	ness		Jaw problems	i
Anxiety Swoller	•	roblems		Low BP	

Asthma			E	Emphyse	ema	Menstrual difficulties	
Tension h	eadach						
Bowel/bladder			ye prol			Migraines	
Bronchitis			ainting			Muscle pains	
Bruise easily				atigue	L L' 1	Osteoarthritis	
Cancer					testinai	problemsParkinson's	
Claustrophobia			ligh BP			Pregnancy # of weeks Rheumatoid Arthritis	
Cold hands/feet			lypogly	Cernia		Kileumatolu Artiinus	
Please list any other	conditic	ons or	sympto	ms not	mentio	ned above:	
							-
Diagraph of our	-£ 4b - 4	:-U:	-				
Please check off any	or the i	Ollowii	ng ther	apies yo	ou nave	previously received:	
Physiotherapy, A	thletic	therap	у,	Massage	e thera	py, Chiropractic, Acupuncture,	
Naturopath, Oth	er						
Please CIRCLE the ar	nswer c	loset to	o how y	ou PRE	SENTL	Y feel: (1- not at all, 5 - completely satisfied)	
Quality of Sleep	1	2	3	4	5	Hours of sleep per night (Approx)	
—— Energy level 1	2	3	4	5		Number of times you exercise per week	
2,		3	4	5			
Eating Habits 1	Z	3	4	5		Number of meals you regularly eat/day	
 Stress Level (low)1 2	2 3 4	5 (hi	gh)				
Smoke		Yes		No		Occasional	
Alcohol	Yes		No		Occa	esional	

Payment Policy:

I understand that I am ultimately responsible for the full cost of my appointments, including any event Where my insurance company (e.g.ICBC, MSP, DVA, and RCMP) should deny their payment portion to the RMTs.

Cancellation/Missed Appointment Policy: I understand that 24-hours notice is required to cancel or Change any appointment. If I miss my appointment, or cancel, or change it, without 24-hours notice, I will be responsible for the full cost of that appointment. (*We thank you for respecting your time, our time, and that of fellow clients.*)

I authorize the clinic and its associated RMTs to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated RMTs to communicate with my referring MD as deemed necessary for my beneficial treatment.

I also understand that my per-	sonal and medical	information is	confidential and v	will only be disc	closed to third
parties with my permission.					

Signature:	Date:
Jigilatulei	Date.

