

Name _____ Address _____
 Birth date(M/D/Y) _____
 Phone (home) _____ ICBC Claim? Y or N
 (Work) _____ Family doctor _____
 (Cell) _____ Occupation _____
 Email _____ How did you hear about us? _____

Please check all of the following that apply (past or current)

- | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Circulatory Conditions (ex. High or low blood pressure, Other heart conditions, Varicose veins, Bruise easily, other) | <input type="checkbox"/> Neurological Conditions (ex. Headaches or Migraines, Dizziness, Fainting, Nausea, Head injury, Spinal injury, Epilepsy, Other) | <input type="checkbox"/> Digestive condition (ex. IBS/Colitis) |
| <input type="checkbox"/> Kidney Conditions (ex. Kidney disease, Diabetes) | <input type="checkbox"/> Respiratory Conditions (ex. Asthma, Chronic sinusitis, Other) | <input type="checkbox"/> Skin conditions |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Contagious Conditions (ex. Hepatitis, HIV) | <input type="checkbox"/> Joint Conditions (ex. Joint dislocation, Arthritis) |
| <input type="checkbox"/> Cancer | | <input type="checkbox"/> Bone Conditions (ex. Fracture/ break, Osteoporosis, Rods/Pins/Plates) |

Medications you presently take _____
 Known allergies _____
 Major accidents, illnesses or surgeries _____

 Activities, sports or hobbies _____

Current Condition

Please describe your current condition and symptoms

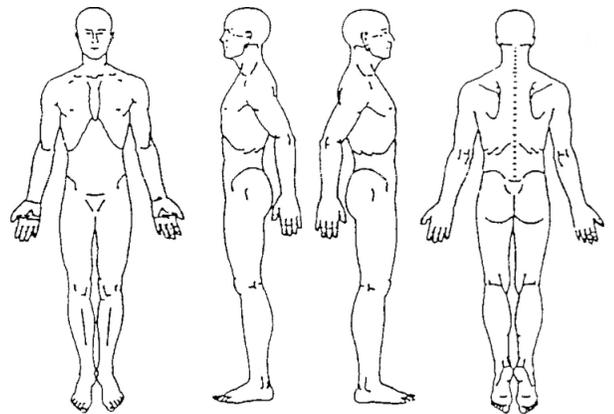
 How long have you had this condition? _____

 How did it start? _____

 What aggravates it? _____

 What relieves it? _____

Indicate the location of your symptoms.



Please note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Email reminders for appointments are a courtesy, if you don't receive one; it is still your responsibility to arrive on time for the appointment. Payment for all treatments, whether private or insured, is ultimately the responsibility of the patient.

I authorize the clinic and its associated RMTs to collect my personal 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/email addresses I have provided. 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 personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature _____ Date: _____

Electronic Billing of Third Party Insurance

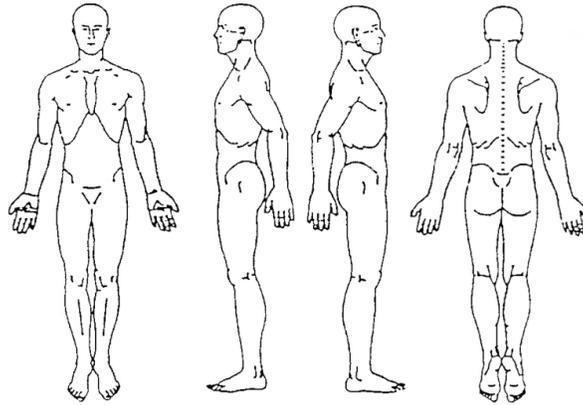
Insurance Provider _____

Plan/Policy # _____ Certificate/Member ID _____

I have read the Electronic Transmission Authorization, Benefit Assignment, and Consent Form. Please initial _____

Print Name (clearly): _____ Signature _____

For Office Use only:



Name: _____