

**Patient Information:** All information on this sheet is confidential and is for clinic use only.

**For returning clients:**

all the information below has not changed from the last time I attended this clinic

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name & Init: \_\_\_\_\_

Health Card #: \_\_\_\_\_ Date of Birth mm/dd/yy) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Prov: \_\_\_\_\_

Postal Code: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_ Work: \_\_\_\_\_

Injury Date: \_\_\_\_\_ Problem Area: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Referring doctor: \_\_\_\_\_

How did you hear about us?  Yellow Pages  Friend  Repeat patient  Website  
 Sign  Doctor (name: \_\_\_\_\_)  Other: \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_

**Employment/School Information:**

Employment Status: \_\_\_\_\_ Employer/School: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax#: \_\_\_\_\_

Occupation: \_\_\_\_\_ Job Title: \_\_\_\_\_

Supervisor: \_\_\_\_\_

**Guardian Information (if under 18 years of age):**

Name: \_\_\_\_\_  (Please check off if at same address as above)

Address: \_\_\_\_\_ City: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

I grant permission to share my confidential health information with my family/referring doctor and other health professionals, within the confines of the clinic, whom are directly involved in my care.

\_\_\_\_\_  
Client or Guardian Signature