



CROSSROADS  
**PHYSIOTHERAPY &  
 MASSAGE THERAPY**

**CONFIDENTIAL PATIENT HISTORY FORM**

Name	_____	Date of Birth	_____
Address	_____	Family Doctor	_____
	_____	Referring Doctor	_____
	_____	Care Card #	_____
Phone	(home) _____	Email	_____
	(mobile) _____	Occupation	_____
	(work) _____		

<p><b><i>If an ICBC claim, please complete:</i></b></p> <p>Claim No. _____</p> <p>Date of MVA _____</p> <p>Driver's License No. _____</p> <p>ICBC Adjuster Name _____</p> <p>Adjuster Phone No. _____</p> <p>Adjuster Fax No. _____</p>	<p><b><i>If a WCB claim, please complete:</i></b></p> <p>Claim No. _____</p> <p>Date of Injury _____</p> <p>Employer _____</p> <p>Employer Phone No. _____</p> <p>Case Manager Name _____</p> <p>Case Manager Phone No. _____</p> <p>Case Manager Fax No. _____</p>
<p><b><i>If you have hired a lawyer to handle your injury claim, please complete:</i></b></p> <p>Lawyer's Name _____</p> <p>Lawyer's Phone No. _____</p>	

How did you hear about our clinic? \_\_\_\_\_

Please indicate if you believe if any of the following apply to you?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Headaches / Migraines                | <input type="checkbox"/> Joint Dislocation         | <input type="checkbox"/> Pregnant       |
| <input type="checkbox"/> High / Low Blood Pressure            | <input type="checkbox"/> Bone Fracture             | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> Stroke or Aneurysm                   | <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Diabetes       |
| <input type="checkbox"/> Spinal Injury                        | <input type="checkbox"/> Osteoporosis              | <input type="checkbox"/> Depression     |
| <input type="checkbox"/> Rods / Pin / Plates                  | <input type="checkbox"/> Hepatitis                 | <input type="checkbox"/> Bruise Easily  |
| <input type="checkbox"/> Varicose Veins                       | <input type="checkbox"/> Epilepsy / other seizures | <input type="checkbox"/> HIV            |
| <input type="checkbox"/> Respiratory Conditions               | <input type="checkbox"/> Cancer _____              |   |
| <input type="checkbox"/> Other Contagious Conditions _____    |  |   |
| <input type="checkbox"/> Previous Surgeries _____             |  |   |
| <input type="checkbox"/> Other Relevant Medical History _____ |  |   |

**Current Condition**

Please describe your current condition & symptoms: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

How did it start? \_\_\_\_\_

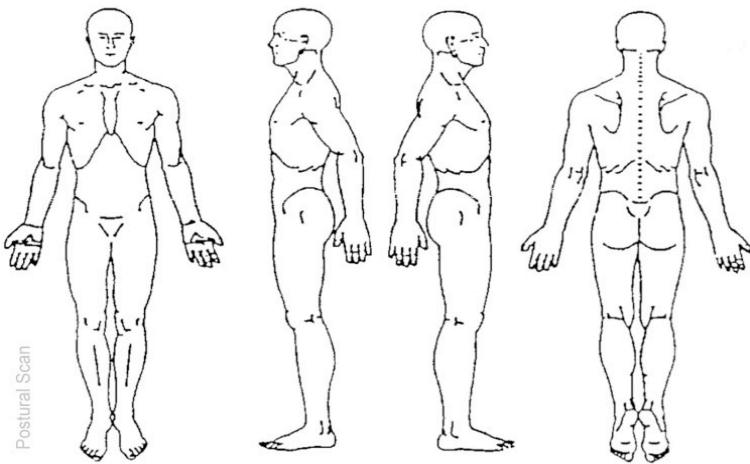
What aggravates it? \_\_\_\_\_

What relieves it? \_\_\_\_\_

Please list any Medications you presently take: (e.g. pain killer, muscle relaxant, anti-inflammatory)

Known allergies (including medications, foods, seasonal, oils and lotions, etc.)

Do you get regular Exercise? Yes / No What kind? \_\_\_\_\_



Please indicate on the diagram the locations of your complaint.

**Payment Policy:** Payment, whether private or insured, is ultimately the responsibility of the patient. In the event that your third party insurer (including MSP, ICBC or WCB) does not agree to cover your visits, your signature below indicates your agreement to pay all fees owing for the care provided.

**Cancellation Policy:** 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 \$20 late cancellation fee will be charged.

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

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