CROSSROADS
PHYSIOTHERAPY &
MASSAGE THERAPY

CONFIDENTIAL PATIENT HISTORY FORM

Name _____
Address _____
_____
_____
Phone (home) _____
(mobile) _____
(work) _____

Date of Birth _____
Family Doctor _____
Referring Doctor _____
Care Card # _____
Email _____
Occupation _____

If an ICBC claim, please complete: Claim No. _____ Date of MVA _____ Driver's License No. _____ ICBC Adjuster Name _____ Adjuster Phone No. _____ Adjuster Fax No. _____	***If a WCB claim, please see the reception staff to fill in the proper form.***
If you have hired a lawyer to handle your injury claim, please complete: Lawyer's Name _____ Lawyer's Phone No. _____	

How did you hear about our clinic? _____

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

_ Headaches / Migraines
_ High / Low Blood Pressure
_ Stroke or Aneurysm
_ Spinal Injury
_ Rods / Pin / Plates
_ On Blood Thinners
_ Respiratory Conditions
_ Other Contagious Conditions _____
_ Previous Surgeries or Blood Transfusions_____
_ Other Relevant Medical History _____
_____

_ Joint Dislocation
_ Bone Fracture
_ Arthritis
_ Osteoporosis
_ Hepatitis / Jaundice
_ Epilepsy / other seizures
_ Cancer _____

_ Pregnant
_ Skin Condition
_ Diabetes
_ Depression
_ Bruise Easily
_ HIV positive

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? _____

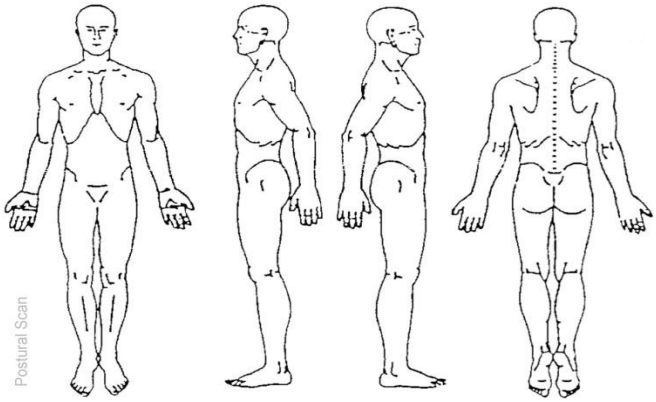
Please list any Medications you presently take: *(e.g. pain killer, muscle relaxant, anti-inflammatory)*

_____

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.

Your signature below indicates you have read and agree to the following:

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, you agree 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 $50 late cancellation fee will be charged.

Shared Medical Record: Our clinic is part of a multi-disciplinary practice with Cross Roads Medical Clinic, Cross Roads Obstetrics and Gynaecology and Cross Roads Naturopathic Clinic. Patient visits are documented on the same electronic health record by all providers associated with that patient.

Signature:_____ **Date:**_____