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) ________		

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
_ Joint Dislocation
_ Bone Fracture
_ Arthritis
_ Osteoporosis
_ Hepatitis / Jaundice
_ Epilepsy / other seizures
_ Cancer ______________
_ Pregnant
_ Skin Condition
_ Diabetes
_ Depression
_ Bruise Easily
_ HIV positive
_ Other Contagious Conditions ______________
_ Previous Surgeries or Blood Transfusions______________
_ 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? ____

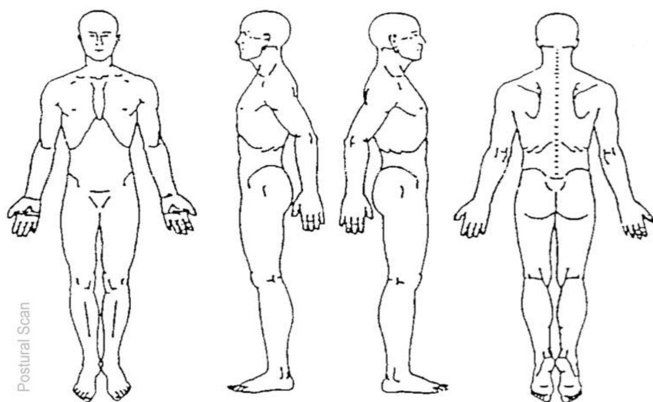
Please list any Medications you presently take: *(e.g. pain killer, muscle relaxant, anti-inflammatory)*

____

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.

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 the cost of the appointment will be charged to you.

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:**________________________