CLINIC INTAKE FORM

REASON FOR YOUR VISIT

PHYSICAL THERAPY

- ☐ MOBILITY, STRENGTH, CHRONIC CONDITIONS, SURGICAL RECOVERY
- ☐ SPORT RELATED ISSUES
- ☐ MOTOR VEHICLE ACCIDENT OR WORKERS COMPENSATION

MASSAGE THERAPY

- ☐ MASSAGE (THERAPEUTIC, HOT STONE, CUPPING, PREGNANCY)

Have you been a client of ours before? _____ If YES, with whom? _____

How did you hear about us? _____ Referred by: _____

Preferred Communication Consent

Do we have your permission to contact you by **text message** and **email** for appointment reminders, important clinic updates, and general information about what's happening at the clinic?

☐ Yes, both ☐ text messages ☐ Yes, emails ☐ No

We use **text messages and email** as our primary methods of sharing important clinic information and sending appointment reminders. **Clients are responsible for keeping track of their appointments**.

PATIENT INFORMATION (CLIENT DEMOGRAPHICS)

Legal Last Name:	Legal First name: ❑ Preferred	Middle name: ❑ Preferred

Do you have a preferred name? ❑ Yes ❑ No	What is your preferred First and Last Name ?	Birth date: (m) (d) (y) / /	Age:	

Email Address:	Primary Phone #:	Secondary Phone #

Street Address:	City:	Province:	Postal Code:

P.O. Box:	City:	Province:	Postal Code:

Emergency Contact

Name:_____ Phone Number:_____ Relationship:_____

EMPLOYER INFORMATION

Occupation:	Employer:	City:	Phone no:

PHYSICIAN INFORMATION

Physician _____ Clinic: _____ Phone no:_____

Referring Physician: _____ Clinic: _____ Phone no:_____

PLEASE PRESENT THE FOLLOWING DOCUMENTS

A copy of the following is required

ALBERTA HEALTH CARE CARD

#:_____

EXTENDED HEALTH INSURANCE

:_____

PATIENT SIGNATURE

The above information is true to the best of my knowledge.

_____	_____	_____
Patient / Guardian Printed Name	Patient / Guardian Signature	Date