

New Patient Intake Form

Last Name: _____	BC Care Card # _____
First name: _____	E-mail _____
Birth date M: _____ D: _____ Y: _____	Extended medical insurance? Y/N _____
Mailing Address _____	Insurance Company: _____
City: _____ Postal Code: _____	Family Doctor: _____
Phone:(home) _____	Referring Doctor: _____
(mobile) _____	Occupation: _____
(work) _____	Employer _____

How did you hear about our clinic?: _____
Which area(s) of the body do you need treated? _____
Have you had any treatments this year? _____
Do you have any relevant medical history?(health conditions, allergies, past injuries) Y/N _____
If yes, please explain _____
Do you take any medications? _____

For ICBC or WCB claims, please complete:

Claim number: _____ Date of accident _____
Adjuster/case manager name _____
Adjuster/case manager phone # _____ fax# _____

If you have hired a lawyer for your claim, please complete:
Lawyer's name: _____ Phone # _____

Informed consent

I hereby consent to assessment and treatment of Physiotherapy care on me by the Registered Physiotherapist and /or anyone working directly under or in conjunction with the Registered Physiotherapist at CIHC.

I consent to communication and/or written reports on this assessment and subsequent follow up treatments being sent to any of the following: my family doctor, my specialist, the case manager or adjuster adjudicating my claim (if applicable).

Others involved in my claim that also have this consent include: _____

Cancellation Policy

I understand that if I do not show up for an appointment or do not give at least 24hr notice to cancel or change my appointment, I will be charged a \$50.00 fee.

NAME: _____ DATE: _____

SIGNATURE: _____ WITNESS: _____