Fifth Avenue Place Chiropractic & Massage

Chiropractic ♦ Acupuncture ♦ Massage Therapy ♦ Physiotherapy ♦ Orthotics

Zoya Imran, M.Sc. P.T.

Welcome! Thank you for choosing our practice for your physiotherapy needs. Please complete this form with your most recent personal information. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

NAME: _____ BIRTHDATE: ____/____/____
MM / DD / YYYY

ADDRESS: _____ HOW DID YOU FIND US: _____

CITY: _____ PROV: _____ POSTAL CODE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____ PLEASE SEND APPOINTMENT REMINDERS: Y N

OCCUPATION: _____ EMPLOYER: _____

EMERGENCY CONTACT : _____ RELATION: _____ PHONE #: _____

IS THIS A: WCB CLAIM ☐ ☐MOTOR VEHICLE ACCIDENT DATE OF INJURY: _____

FAMILY DOCTOR: _____ CLINIC NAME: _____ PHONE: _____

REASON FOR VISIT: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

PLEASE LIST ANY HEALTH CONDITIONS YOU CURRENTLY HAVE: _____

PLEASE LIST ANY PREVIOUS SURGERIES: _____

DO YOU CONSENT TO SHARE YOUR INFORMATION WITH YOUR FAMILY PHYSICIAN: YES NO INITIAL: _____

I UNDERSTAND AND AGREE TO AN ASSESSMENT AND TREATMENT PROGRAM. MY CONSENT IS VOLUNTARY FOR THE ENTIRE COURSE OF ASSESSMENT AND TREATMENT FOR MY PRESENT CONDITION, COMMENCING ON THE DATE INDICATED BELOW. I UNDERSTAND THAT I MAY ASK QUESTIONS AT ANY TIME, AND THAT MY CONSENT MAY BE WITHDRAWN IN WRITING AT ANY TIME, EXCEPT FOR ACTIONS ALREADY TAKEN.

Consent to Assessment and to Treatment

_____ _____
Client Signature Date

_____ _____
Physiotherapist Signature Date