

Soma Physiotherapy

Patient Information and Consent to Treatment Confidential Medical History

Personal Information (please print)

Name: _____ Last, First		
Date of Birth: _____ D/M/Y	Gender: Male/Female	
Street: _____		
City/Town: _____	Postal Code: _____	
Home Phone #: _____	Cell #: _____	Work #: _____
e-mail: _____ Your email will only be used to send you appointment confirmations, reminders and a clinic newsletter.		
Occupation: _____		
Family Doctor: _____	Referring Doctor: _____	

Please circle all conditions that apply either presently or previously:

Cardiovascular High/Low blood pressure / Heart disease / Stroke / Heart attack / Pacemaker / Bleeding disorder / Circulatory condition

Respiratory Asthma / Bronchitis / Smoking

**Digestive/
Uro-genital** Intestinal condition / Kidney condition / Liver condition / Diabetes

Female Menopause / Pregnant – due date _____

Musculoskeletal Osteoporosis / Arthritis / Fracture / Dislocation / Neuralgia

Head/Neck Dizziness / Double vision / Ringing in the ears / Nausea / Headaches / Jaw pain

Accidents/Surgeries Please list: _____

Other Cancer / Seizures / Allergies / Other: _____

• Reason for Visit: _____

• Is this related to an ICBC or work injury: Yes/No _____

• Have you seen any other health practitioners? _____

• Date of onset: _____

• Please list any medications you are currently taking: _____

How did you hear about Soma Physiotherapy? _____

Consent and Cancellation Policy:

I, _____, give consent for physiotherapy assessment and treatment at Soma Physiotherapy. I am aware there is a 24 hour cancellation policy. If I fail to cancel 24 hours prior to my appointment or I arrive late, the entire treatment fee will be my responsibility.

Signature

Parent or Guardian (if under 18)

Date