SOUTH DELTA PHYSIOTHERAPY CLINIC

107 – 1077 56TH STREET TSAWWASSEN, BC V4L 2A2 PH 604.943.3518 FAX 604.943.0893

Name: _____

DOB: _____ **Gender:** _____

Address: _____

Phone: _____ **Email:** _____

Emergency Contact:

Name: _____ **Number:**_____

Family Doctor: _____

Medical History - Do any of the following apply?

❑ Heart Problems	❑ Pacemaker	❑ History of Strokes
❑ Pregnancy	❑ Plastic or Metal Implants	❑ Recent Surgeries
❑ Asthma	❑ Allergies	❑ Ever Treated for Cancer
❑ Diabetes	❑ Osteoporosis	❑ Car Accidents

❑ Medications_____

Other Major health issues:

_____

_____

I am at South Delta Physiotherapy Clinic today as a result of:

❑ **Doctor's Referral** name_____

❑ **Friend or Family** name_____

❑ **Health Professional** name_____

❑ **Advertising** ❑ Social Media ❑ Newspaper ❑ Website ❑ Clinic Sign

❑ **Other** _____

Consent

I, _____, give consent to the assessment and treatment given to me by the therapists at South Delta Physiotherapy Clinic.

Cancellation Policy

Your appointment time is reserved for you. As a courtesy to others, please give 24 hours cancellation notice if you are unable to attend. There may be a $25 charge for missed appointments.

I have read the above and understand it. **Todays Date:** _____

_____

Signature