Last Name, First Name		Email Address		
Is this your preferred name? ❑ Yes ❑ No	If No, please indicate your preferred name.	Birth date (MM.DD.YR)	Age:	Sex: ❑ M ❑ F
Home address:		Home Phone Number: ( )	Cell Phone Number: ( )	
City:	Province:	Postal Code:	Personal Health Number (PHN):	
Occupation:	Employer:		Work Phone Number ( )	
Referred to clinic by (please check one box):	❑ Dr. ______________________	❑ Google	❑ Yelp	
❑ Friend/Family Member: ____________________	❑ Close to home/work	❑ Yellow Pages	❑ Other: ______________________________________	

Family Physician Name:

Family Physician's Clinic Name and/or Phone Number:

EXTENDED HEALTH INFORMATION

Extended Health Insurance Provider: ❑ Great West Life ❑ Sunlife ❑ Blue Cross ❑ Manulife ❑ Other: ________________________

Extended Health Card Number:

Name of the Primary Card Holder:

Primary reason for visit (Please Describe):

Is today's visit related to a motor vehicle accident or workplace injury?
❑ Yes
❑ No

If YES, please list the following -

Date of the Accident:

Claim Number:

Adjuster Name:

Adjuster Phone Number:

EMERGENCY CONTACT

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

MISSED APPOINTMENT POLICY

I understand that I am financially responsible for medical services provided to me and missed appointments. If I am unable to keep an appointment, I must provide the clinic at least 24 hours' notice to cancel otherwise the full amount of the treatment will be invoiced. There are three ways to modify/cancel an existing appointment:

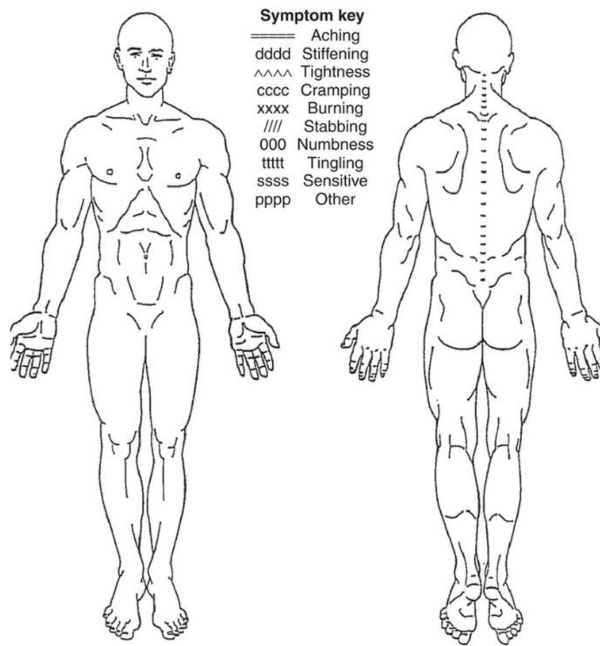
1. **Call the clinic: 604-430-1525**
2. **Visiting our website and logging onto our online booking platform (www.metrotownchiropractic.com)**
3. **Email metrochiro@telus.net**

We appreciate that you value our practitioners' time, and we look forward to working with you.

By Signing below, I consent to the above "Missed Appointment Policy"

Patient/Guardian signature *Date*

Please Indicate the Location of your Complaint



HEALTH QUESTIONNAIRE

Please list any medications you currently take:
Do you have a history of cardiovascular disease, or any other medical conditions?
Have you ever had any fractures? If yes, where and when?
Do you suffer from headaches?
Have you sought previous therapy for this complaint? (eg. Physiotherapy)
Please add any additional comments:

CONSENT TO TREATMENT

Patient Name:______________________________ DOB: (dd/mm/yy): ___/___/___

- **Read this document, including Schedule "A", carefully and completely. It is important.**
- Please be sure to ask your RMT any questions you have about this form or its contents BEFORE you sign this document.
- You have the right at any time to ask questions about your treatment.
- Please be sure to immediately advise your RMT if you become uncomfortable with any aspect of your treatment, so that they may stop and discuss it with you.

The Treatment: I authorize and consent to the RMT performing the following specific treatments on me:

__ Soft Tissue Mobilization __Joint Mobilization __Exercise Therapy
__Other:____

Risks, Complications & Side Effects: I acknowledge and understand that:

- There are risks associated with any manual therapy techniques, including those techniques used by Registered Massage Therapists. Examples include bruising, aching, discomfort, short term aggravation of symptoms, muscle and ligament strains, sprains and skin irritation;
- **I have discussed any specific concerns I have about possible risks with my Therapist before signing this document**;
- The nature and purpose of the above treatments, the possible alternative methods of treatment, the risks involved and the possible complications and side effects have been fully explained to me by the RMT;
- I do not expect the RMT to be able to anticipate and explain all possible risks, complications and side effects of my treatment(s) to me; and
- I wish to rely on the RMT to exercise their judgment during the course of the treatment to provide the treatment that is in my best interests.

Disclosure of Medical History: I acknowledge and understand that:

- It is important for the RMT to know my medical history as it may relate to my treatment(s);
- I have disclosed to the RMT in writing all medical conditions, including any mental or emotional conditions for which I have received treatment, currently affecting me and those that have affected me in the past;
- I will immediately disclose in writing any medical condition that I subsequently realize I have not already disclosed, including any new condition that may develop after my completion of this form; and
- The information disclosed by me is true and complete to the best of my knowledge.

Confidentiality: The contents of this form and my patient records will be kept confidential unless I have expressly or impliedly consented to the release of my information or where there is a legal requirement to provide my information to a third party.

No Guarantee of Results: I acknowledge and confirm that no guarantee or assurance of results has been made to me regarding my treatments.

Signature of Patient*: ________________________________ Date: (dd/mm/yy): __/__/__

(* In the case of a person incapable of providing consent, signature of Parent or Guardian, in which case the Name & Relationship of Person Signing: ______________________________.)