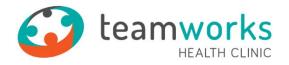


Welcome to Teamworks Health Clinic

Full Name: (as it appears on your Care Card)									
Former Name/Preferred Name (if applic.):									
Date of Birth (DD/M	M/YYYY):								
Care Card Number:									
Street Address (Apt. # if applic.):									
City/Province:			Postal Code:						
Home Phone:				Cell Phone:					
Occupation:									
Work Phone:									
Email:									
Emergency Contact Name:				Emergency Contact Number:					
Physician's Name:				Physician's Number:					
Other Health Care Providers:				Other Health Care Providers' Numbers:					
How did you hear about our clinic?									
Please enter specific details (name of friend, doctor, event, etc.):									
Type of treatment you are seeking? (Check all that apply)									
Chiropractic ART		Massage Therapy Injury Prevention		cupuncture rthotics		s/Nutritional Counseling rative Care Program			
Previous treatment(s) for this condition:									
Have you, or will you be submitting a claim to:		ICBC:	Acce	pted	Pending	Have Legal Counsel			
		WorkSafe BC:	Acce	pted	Pending	Have Legal Counsel			
Claim Number (specific to this injury):			Adjuster's Name:						

Adjuster's Phone:

Date of Injury/Accident:



Please describe the nature of your injury (i.e. location, symptoms, impact on activities of daily living or sport participation, etc.)

MEDICAL HISTORY

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING:

Abdominal Problems Dislocations Numbness or Tingling
Arthritis Dizziness Polio/Post-Polio Syndrome
Asthma Fractures Psychiatric or Psychologica

Asthma Fractures Psychiatric or Psychological Care
Artificial Joint Gastrointestinal Disorder Recent Weight Loss or Gain

Balance Problems High/Low Blood Pressure Respiratory Condition

Blurred or Double Vision Headaches Seizures

Cancer / History of Family History of Heart Disease / Family History of Shortness of Breath

Chest Pain Herniated Disc Skin Condition
Concussion Hot or Cold Intolerance Sleep Disorder

Currently Pregnant Nausea/Vomiting Stroke
Diabetes Neurological Disorder Ulcers

Difficulty Swallowing/Eating Osteoporosis/Low Bone Density Vascular Disease

Other:

Please list all surgeries and/or significant injuries/accidents (with approximate date):

Please list all medications and/or supplements currently being taken:

Are you currently a smoker? YES NO If yes, how many cigarettes per day?:____

Have you smoked in the past? YES NO

PHYSIOTHERAPY CHIROPRACTIC
MASSAGE THERAPY DIETETICS
ACUPUNCTURE AND MORE

Please list any illnesses or conditions that run in your immediate family:

Teamworks offers <i>Complimentary Consultations</i> for all of the different services provided at the clinic.	Check if you are
interested in booking a Complimentary Consultation (check all that apply):	

Physiotherapy Chiropractic Massage Therapy Acupuncture Dietitian Kinesiology

CANCELLATION POLICY

The time of your appointment has been specifically set aside for you. We require 24 hours notice for cancellation of an appointment. You will be charged the entire visit fee for a missed appointment or short-notice cancellation. As a courtesy to you, we are willing to change appointment times to better suit your needs with adequate notice, or in the event of an emergency.

The above information is true to the best of my knowledge. I consent to the sharing of my records between practitioners of Teamworks Health Clinic as well as with my medical doctor and outside healthcare practitioners in order to integrate and facilitate my care. I consent to receiving voice messages and email reminders about my upcoming appointments or my care at Teamworks Health Clinic.

I consent to receiving occasional contact from Teamworks Health Clinic by email (quarterly newsletter, important policy changes, etc.).

Patient's Signature:	Date:	Date:		
Parent's Signature:				
(if patient is under 18 yrs)	Date:			