teamworks HEALTH CLINIC

PHYSIOTHERAPY
MASSAGE THERAPY
ACUPUNCTURE
CHIROPRACTIC
DIETETICS
AND MORE

Welcome to Teamworks Health Clinic

Full Name: **(as it appears on your Care Card)**	
Former Name/Preferred Name (if applic.):	
Date of Birth (DD/MM/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 select an item from the dropdown menu

Please enter specific details (name of friend, doctor, event, etc.):

Type of treatment you are seeking? (Check all that apply)

☐ Chiropractic ☐ Physiotherapy ☐ Massage Therapy ☐ Acupuncture ☐ Dietetics/Nutritional Counseling
☐ ART ☐ Kinesiology ☐ Injury Prevention ☐ Orthotics ☐ Collaborative Care Program

Previous treatment(s) for this condition:

Have you, or will you be submitting a claim to:	ICBC:	☐ Accepted	☐ Pending	☐ Have Legal Counsel
	WorkSafe BC:	☐ Accepted	☐ Pending	☐ Have Legal Counsel

Claim Number (specific to this injury):	Adjuster's Name:
Date of Injury/Accident:	Adjuster's Phone:

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
- ☐ Arthritis
- ☐ Asthma
- ☐ Artificial Joint
- ☐ Balance Problems
- ☐ Blurred or Double Vision
- ☐ Cancer /History of/Family History of
- ☐ Chest Pain
- ☐ Concussion
- ☐ Currently Pregnant
- ☐ Diabetes
- ☐ Difficulty Swallowing/Eating
- ☐ Other:
- ☐ Dislocations
- ☐ Dizziness
- ☐ Fractures
- ☐ Gastrointestinal Disorder
- ☐ High/Low Blood Pressure
- ☐ Headaches
- ☐ Heart Disease /Family History of
- ☐ Herniated Disc
- ☐ Hot or Cold Intolerance
- ☐ Nausea/Vomiting
- ☐ Neurological Disorder
- ☐ Osteoporosis/Low Bone Density
- ☐ Numbness or Tingling
- ☐ Polio/Post-Polio Syndrome
- ☐ Psychiatric or Psychological Care
- ☐ Recent Weight Loss or Gain
- ☐ Respiratory Condition
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Skin Condition
- ☐ Sleep Disorder
- ☐ Stroke
- ☐ Ulcers
- ☐ Vascular Disease

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

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

Teamworks offers ***Complimentary Consultations*** 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: _____

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