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? Friend/Family Co-Worker Doctor Marketing Material (Brochure, etc.) Online Social Media Health Care Provider (Physio, Chiro, etc.)

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

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

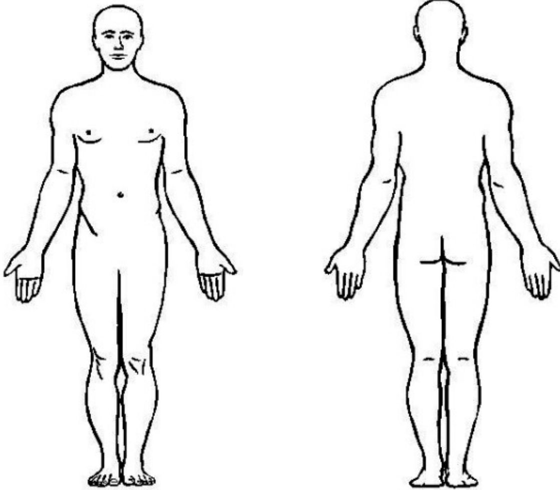
Chiropractic	Physiotherapy	Massage Therapy	Acupuncture	Dietetics/Nutritional Counseling
ART	Kinesiology	Injury Prevention	Orthotics	Collaborative Care Program

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:

On the figure below, please mark any areas (with a circle) where you feel pain or discomfort in your body. If the pain travels anywhere, please indicate this using arrows.



Please list complaints in order of severity:

1.____

2.____

3.____

4.____

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 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

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: _________________________