

**GENERAL INFORMATION**

**NAME:** Last: \_\_\_\_\_, First \_\_\_\_\_ Middle Initial \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_, City \_\_\_\_\_, Province \_\_\_\_\_ Postal Code \_\_\_\_\_  
 Phone: Home: 250 \_\_\_\_\_ Work: 250 \_\_\_\_\_ Cell: 250 \_\_\_\_\_ E-mail (optional) \_\_\_\_\_  
 Date of Birth: Month: \_\_\_ Day \_\_\_ Year \_\_\_\_\_ (Do you wish to be reminded of appointments? No \_\_\_ Yes \_\_\_ by \_\_\_\_\_)  
 Job Title: \_\_\_\_\_ Work Location: \_\_\_\_\_  
 Emergency Contact: Name \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
**Name of Family Doctor:** \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_ City: \_\_\_\_\_  
 Is this a claim to ICBC \_\_\_ WCB \_\_\_ DVA \_\_\_ RCMP \_\_\_ Referral from GP: Y or N  
**Reasons for your visit (i.e. symptoms):** \_\_\_\_\_  
**Interested in?** Physiotherapy \_\_\_\_, Acupuncture \_\_\_\_, Cranio-sacral \_\_\_\_, Lymphatic Drainage \_\_\_\_, Other \_\_\_\_\_  
**How did you hear about us?** Yellow Pages \_\_\_\_, Web site \_\_\_\_, Elevator Ad. \_\_\_\_, Friend \_\_\_\_, Doctor \_\_\_\_, Other \_\_\_\_\_

**MEDICAL HISTORY:** \* If you have a contagious condition, please let us know prior to therapy.

**General Health:** Please **check** one or more **box** [ ] if you have or had any of the following:

[ ] Heart Condition	[ ] TMJ/ Jaw problem	[ ] Headaches / Sinusitis	[ ] Neurological Condition
[ ] Diabetes	[ ] Cancer	[ ] Arthritis	[ ] Bronchitis/Asthma
[ ] High Blood Pressure	[ ] Positive HIV	[ ] Hepatitis A B C	[ ] Other:

**Are you pregnant?** [ ] Yes [ ] No **Do you have a heart pacemaker?** [ ] Yes [ ] No  
**X-ray(s)?** (Related to this injury) [ ] Yes [ ] No **Date of X-ray(s):** \_\_\_\_\_  
**Describe any fractures or surgeries you have had:** {mention year of occurrence(s)}  
 Fractures: \_\_\_\_\_ Surgeries: \_\_\_\_\_  
**Are you seeing other health practitioners?** (a) Chiropractor; (b) Massage Therapist; (c) Ortho. Surgeon; (d) other \_\_\_\_\_  
**Medications you are taking:** \_\_\_\_\_

**COVERAGE:** Fill Out Section That Applies To You.

**BC Health Care Card (PHN) #** \_\_\_\_\_  
 Are you on **Premium Assistance** (annual income of less than \$28,000 from previous year) Yes \_\_\_ No \_\_\_  
 If yes, MSP partially covers up to 10 visits per year. **Our charge per visit is \$20.** You may also need to sign a billing form.

**ICBC** :( for **Motor Vehicle Accidents**) **PHYSIOTHERAPY MUST BE APPROVED BY ICBC PRIOR TO RECEIVING TREATMENT** Claim #:  
 \_\_\_\_\_ Date of Accident: \_\_\_\_\_ Adjuster's Name: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_ Lawyer:  
 \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_  
 \*PLEASE PROVIDE ALL ICBC INFO: # APPROVED VISITS; TIMEFRAME IN WHICH ALL VISITS MUST BE USED; AREA OF INJURY ETC.

**D.N.D. /V.A.C. /R.C.M.P.:** Service # \_\_\_\_\_ Authorized for # \_\_\_\_\_ of treatments  
 Doctor: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_  
 Base/Office/Station/Squadron \_\_\_\_\_  
 Authorization contact name & #: \_\_\_\_\_  
 \*PLEASE PROVIDE ALL DOCUMENTATION: # APPROVED VISITS; AUTHORIZATION#, ETC.

Terms and Conditions: (If you agree with the terms and conditions set below, please sign and date this form)  
 1) I consent to undergo treatments by a health care professional practicing at **Yarrow Physiotherapy & Acupuncture.**  
 2) I agree to pay the fees for my treatments including any fees not paid for or rejected by my insurance plan, i.e. MSP, ICBC, WCB, etc.  
 3) I will pay all charges for: (a) missed appointments or late cancellations, (c) late arrival for treatments, and (d) late payments.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_