Shelbourne Physiotherapy-Cook Street Clinic

Confidential Case History

Name: _____
First Middle Last

Address: _____ Postal Code: _____

Home: _____ Work: _____ Cell: _____

Email:(for apt reminders only) _____

Care Card #: _____ Date of Birth: _____
Month / Day / Year

Family Doctor: _____

Referring Physician: _____

Area(s) to be treated: _____

How did you hear about Shelbourne Physiotherapy?

_____

I consent to physiotherapy treatment and acknowledge that a $25 fee ($35 for IMS) will be charged for any missed appointments that are not cancelled with 24 hours notice.

Signed: _____ Date: _____

Funder Information:

Please circle: ICBC WCB DVA/DND Other

Claim #: _____ Adjuster: _____

Date of Injury/Accident: _____ Lawyer: _____

For Office Use:
Comments: _____

_____

_____

_____

_____

Chart Prepared By:

Your personal information is being collected, used, and disclosed only in compliance with the BC *Personal Information Protection Act.*