westwood
TOTAL HEALTH

RMT - CONFIDENTIAL PATIENT INTRODUCTION

SURNAME:_____ FIRST NAME: _____

ADDRESS:_____

CITY:_____POSTAL CODE: _____

(PHONE NUMBERS) CELL:_____ WORK:_____

HOME:_____ EMAIL:_____

DATE OF BIRTH:_____ OCCUPATION:_____

EMERGENCY CONTACT:_____PHONE:_____

DO YOU HAVE AN OPEN ICBC_____

HOW DID YOU HEAR ABOUT US?_____

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Recent treatment: RMT Chiro Physio Other

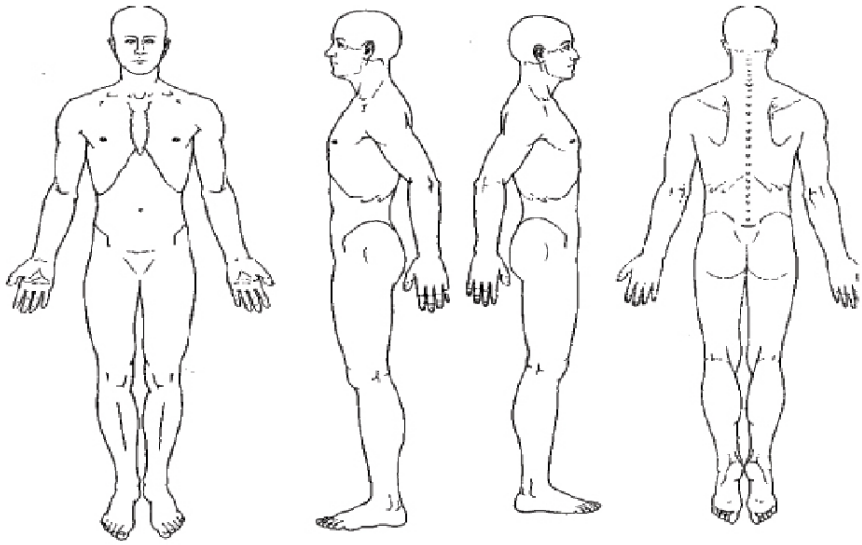
Medication:

Major Illness, accident, surgery, implants?:

Do any of the following apply to you?
(*Past and present*)

- Cancer
- Diabetes
- Epilepsy
- Arthritis
- Heart condition
- High/low BP
- Arterial disease
- Varicose veins
- Respiratory problems
- Digestive problems
- Kidney problems
- Headaches
- Allergies
- Dizziness
- Nausea/vomiting
- Contagious disease
- Other:_____

Please indicate painful areas:



Chief Complaint:_____
When/how did this condition begin: _____
What aggravates it:_____
What relieves it: _____
If you are experiencing pain, stiffness, swelling, or limitation of movement, please list:_____
Do you have a pending ICBC claim?_____

HAVE YOU EVER:

Been hospitalized for other than surgery	Y	N
Been treated for a spine or nerve disorder	Y	N
Used a cane, crutch or other support	Y	N
Been knocked unconscious	Y	N

DATE OF LAST:

	Within 12 months	Over 12 months
Physical Exam	_____	_____
Spinal X-ray	_____	_____
Blood Test	_____	_____
Urine Test	_____	_____

FOR WOMEN ONLY:
Date of last period: _____ Could you be pregnant? Y N Maybe

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PATIENT – THERAPIST AGREEMENT:
Patients are responsible for their accounts with us. **PAYMENT IS DUE WHEN SERVICE IS RENDERED.** If you cannot fulfill the agreement made with us, please advise us immediately.

30 minute visit……..$65.00

60 minute visit……..……$120.00

It is our office policy to charge a fee equal to the visit fee if 24 hours notice is not given for the cancelation/miss of any appointment.

I UNDERSTAND AND AGREE TO ABIDE BY THE ABOVE STATED POLICIES WITHIN THIS OFFICE. I ALSO UNDERSTAND THAT FEES ARE DUE WHEN SERVICES ARE RENDERED, AND THAT I AM RESPONSIBLE FOR PAYMENT.

_____ _____
Patient's Signature Date