ASSURED HEALTH
PHYSIOTHERAPY

New Patient Intake Form

First Name: _____ Last Name: _____ Male / Female

Birth date (Day/Month/Year):_____ Marital Status: Single / Married

Telephone (Home): _____ (Work):_____(Cell):_____

Home Address: _____ City:_____

Postal Code: _____ E-Mail _____

Family Doctor: _____ Phone: _____

Fax: _____

Employer: _____ City:_____

►How Did You Hear About Us?

☐ Doctor's referral ☐ Flyer ☐ Referral from Family or Friend

☐ Walked by the clinic ☐Website ☐ Other: _____

Thank -you, we appreciate your feedback.

Patient Signature:_____ Date:_____

If the patient is under 16 years of age or if mentally challenged, a parent or guardian must sign below.

I, _____ am the parent/guardian of the above named patient and I consent to examination and treatment of this patient.

Signature of parent/guardian: _____