Weber Physiotherapy Clinic Inc.

5420 45th Street Red Deer, AB T4N 1L1
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Your name PLEASE PRINT	**First:**	**Last:**	
Date of Birth	**Month:**	**Day:**	**Year:**
Address:			
City:		**Province**	**Postal Code**
Cell Phone Number:		**Home/Other Phone Number:**	
Alberta Health Care Number:			
Email Address: (for online booking)			
Physician:		**How did you hear about the clinic?**	**Occupation:**
If you are under the age of 18:	**Name of Parent/Guardian:**	***** Please be aware that we DO NOT DO ANY WCB or Alberta Health Care claims*****	
Benefits Provider:	**Policy Number:**	**Group Number:**	
Primary Card Holder:	**Cert/ ID #:**		

PAST MEDICAL HISTORY

DO YOU HAVE A PACEMAKER? YES/NO

(Please circle all that apply) Heart problems/ Hypertension/ Diabetes/ Hypoglycemia/ Cancer/ Seizures/ Thyroid Dysfunction/ DVTs/ Asthma/ Chronic Bronchitis/ Smoker/ Osteoarthritis/ Rheumatoid Arthritis/ Stroke/ Kidney Problems/ Depression/ Preeclampsia/ Osteoporosis

Previous Surgeries:_____

Epilepsy/ Seizures/ Head Injury/ Dizziness/ Fainting Spells:_____

Allergies/ Other Medical Conditions:_____

Medications:_____

***** PLEASE BE AWARE THAT OUR CANCELATION POLICY REQUIRES AT LEAST 24 HOURS' NOTICE OR YOU WILL BE CHARGED THE FULL AMOUNT FOR YOUR APPOINTMENT*****

Consent to receiving rehabilitation services from
WEBER SPORTS PHYSIOTHERAPY CLINIC INC.

Services may include: heat therapy, muscular stimulation, acupuncture, joint/spinal mobilization/manipulation, myofascial release, interferential, gait analysis, and exercise prescription.
Personal information about me may be shared amongst health professionals and others who are providing services to me.

Knowledge that no guarantees have been made to me as to the results of the services. This consent is effective until such time that I withdraw my consent in writing.

_____ (Signature of Client or legal Guardian) Date:_____