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CLIENT INFORMATION FORM

(PLEASE MAKE SURE TO FILL OUT THIS FORM ENTIRELY, INDICATING N/A IF NOT APPLICABLE)

Date:____________________________Form completed by:__________________________________

First Name:____________Last Name:__________Date of Birth:_________________Age:_________

Gender: ☐Male ☐Female ☐Other (Describe):____

Address____

City:_______________Prov:________Postal Code:________

Home phone:___________________________ Cell phone: ____________________________

Work phone:___________________________ Email: _________________________________

Preferred Contact Method: ☐Home ☐Cell ☐Work ☐Text ☐Email

PRIMARY PHYSICIAN

Name:__________________________Phone #:__________________Date of Last Visit:___________

Address:________________________City:_____________________Prov.:_____________________

EMERGENCY CONTACT INFORMATION

Name:__________________________Relationship to Client:________________________________

Address:________________________City:_____________________Prov.:_____________________

Home #:________________________Cell #:__________________________Work #:____________

*IF CHILD OR TEEN

Legal Guardian Name:____

Relationship to client: ☐Parent ☐Other (check one. If other, specify)____________________

Address:________________________City:_____________________Prov.:_____________________

Home #:________________________Cell #:____________________Work #:__________________

REFERRAL INFORMATION

Who referred you to this office?____

Phone #:_________________Address:_________________City:_______________Prov.:________