Check any of the following that may apply to you:

Past/Present Past/Present Past/Present

Heart Cond’n ( ) ( ) Pregnancy ( ) ( ) Epilepsy ( ) ( )

Circulatory Cond’n ( ) ( ) Headaches ( ) ( ) Hernia ( ) ( )

Cancer ( ) ( ) Dizziness ( ) ( ) Depression ( ) ( )

Haemophilia ( ) ( ) Fainting ( ) ( ) Arthritis ( ) ( )

Diabetes ( ) ( ) Jaw Pain ( ) ( ) Osteoarthritis ( ) ( )

Lung Disorder ( ) ( ) Hepatitis ( ) ( ) HIV/AIDS ( ) ( )

M.S. ( ) ( ) Nervousness ( ) ( ) Plates/Pins ( ) ( )

Cerebral Palsy ( ) ( ) Anxiety ( ) ( ) Insomnia ( ) ( )

↑/↓ Blood Pressure ( ) ( ) Stroke ( ) ( ) Spinal Injury ( ) ( )

Rheumatism ( ) ( ) Seizures ( ) ( ) Head injury ( ) ( )

Hypoglycaemia ( ) ( ) Sprain ( ) ( ) Varicose Veins ( ) ( )

Muscle Cramp ( ) ( ) Infection ( ) ( ) Contagious Cond’n ( ) ( )

Allergies ( ) ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On the diagram, indicate area with symptoms:

**X= Pain /////=Tightness B=Burning N=numbness T=Tingling**

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**FEE POLICY**

In consideration of your fellow patients and your therapist, please allow a minimum **2 hours notice** to change your appointment. **Cancellation within 24 hrs** of your appointment will be subject to a **50% charge. No shows are subject to a 100% charge.**

I authorize the clinic and its associated practitioners to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers provided. In addition, I authorize the clinic and its associated practitioners to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_