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dynamic
Physiotherapy and Chiropractic

Patient Intake Form

Last name:	First name:	Circle: M/F	Date of birth (dd/mm/yy):
Address	City:		Postal Code:
Home Phone:	Work:		Cell:
Emergency number:	Date of Injury:		Area of Injury:
Currently working: Yes No	Email:		

Family Physicians Name: _____

Phone #: _____ Address: _____

□ I authorize the release of all necessary information including status updates to my primary care provider, physician, and/or to a co-treating practitioner at Dynamic.

Who referred you to Dynamic Physiotherapy and Chiropractic? : _____

Do you have extended health care : Yes___ No___

If yes: insurance company_____ policy #_____ ID #_____

Is this injury a result of a workplace injury (WSIB): Yes___ No___

If yes: claim number:_____ adjuster name:_____

Is this injury a result of a motor vehicle accident (MVA): Yes___ No___

If yes: claim number:_____ Policy number:_____

Insurance company:_____ Address:_____

Dated this_____ day of_____, 20_____.