Client Name: ____ Phone Number: ___________________________

Diagnosis: ____ Date of Birth: ____________________________

FREE PARKING AVAILABLE

☆ PRECAUTIONS____

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☆ xray/lab____

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NOTES:____

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SERVICES:

PHYSIOTHERAPY	☐	PELVIC THERAPY	☐
MASSAGE THERAPY	☐	ATHLETIC THERAPY	☐
CUSTOM ORTHOTICS	☐	CUSTOM BRACING	☐
SHOCKWAVE THERAPY	☐	Other______________________	☐

Motor Vehicle Insurance ☐ **Extended Health Benefits** ☐ **WSIB** ☐ **Private Pay** ☐

Physician's Signature: ______________________________ **OR** **Physician's Stamp**:

Telephone number: __________________________________

NOTES:

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33 City Centre Drive, Suite 420; Mississauga, On, L5B 2N5; Tel 289-724-2007