



CLIENT INFORMATION

PERSONAL INFORMATION

NAME: _____

ADDRESS: _____

CITY: _____ POSTAL CODE: _____

TEL. # (Home): _____ (Work): _____ (Cell): _____

OCCUPATION: _____ BIRTHDATE: _____
(mandatory) dd / mm / yyyy

E-MAIL ADDRESS: _____

I consent to having VOR contact me for appointment reminders and appropriate correspondence

EMERGENCY CONTACT (required)

NAME: _____ PHONE #: _____
(Relationship)

REFERRING HEALTH CARE PROFESSIONAL

NAME: _____ PHONE #: _____

FAMILY PHYSICIAN

NAME: _____ PHONE #: _____

Current Medications (please list): _____

Have you ever experienced or are you currently experiencing any of the following:

- | | | |
|--|--|-------------------------------------|
| <input type="checkbox"/> Asthma / Breathing difficulties | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Heart disease/Heart attacks | <input type="checkbox"/> Depression/ Anxiety | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Migraines/chronic headaches | <input type="checkbox"/> Concussion |

Are you currently pregnant? Yes No

Previous surgeries _____

Are there any other conditions that your family physician follows on a regular basis: _____

