eastman
THERAPY CENTRE

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Unit 6 – 380 Stone Bridge Crossing
Steinbach, MB R5G 2R1
eastmantherapycentre@hotmail.com

DOCTOR INTAKE FORM

PATIENT INFORMATION

First Name: _____ Last Name: _____

Address: _____ City: _____ Postal Code:_____

Date of Birth (DD/MM/YY): _____ Email Address: _____

Phone Number: *Home* _____ *Cell* _____ *Other* _____

Preferred Method of Appointment Reminder *(Circle One)* Phone *or* Email *or* Text

Have you seen a physician for this injury in the past? Yes or No

If "Yes", who? _____

Have you received therapy for this injury in the past? Yes or No

If "Yes", where? _____

Who referred you to our clinic? _____

*Please note that this is not the home office of our doctors.

OFFICE USE ONLY (Please do not fill out)

Referring Physician: _____

Physician seen today: Dr. P Fredette Dr. J Longstaffe Dr. R Longstaffe

PHIN# (9-digit) _____ MB # (6-digit) _____

Notes:

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