



ACTIVE HEALTH CENTRE
5871 Highway 7 East, Suite 101
Markham, Ontario L3P 1A3
T: 905-294-0454
F: 905-294-0480

PHYSIOTHERAPY PATIENT INFORMATION
(Please print)

Please tell us about yourself (Please print)

Name: _____

Address: _____ City: _____ Postal Code: _____

Date of Birth: D ___ M ___ Y ___ Age: ___ Gender: M F

Marital Status: Single Married Widowed Divorced

Social Insurance Number: _____

Email: _____

Home Phone: _____ Leave Message: Yes No

Work Phone: _____ Leave Message: Yes No

Mobile Phone: _____ Leave Message: Yes No

What is your Occupation? _____

Duties: _____

Name of Business: _____ Phone: _____

Address of Business: _____ City: _____ Postal Code: _____

Emergency Contact: _____ Phone: _____

Referred by: _____ e.g. patient/sign/ad/etc.

Medical Doctor: _____ Phone: _____

Address: _____ City: _____ Postal Code: _____

Chief Complaint:
