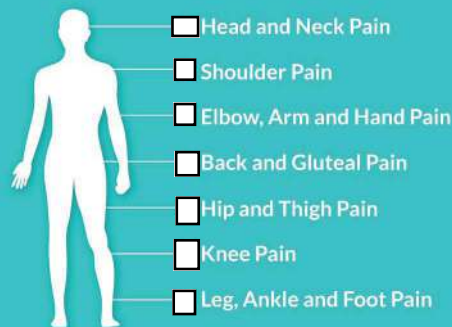


Patient's Name: _____

Patient's Address: _____

DOB: _____ Phone: _____

Patient's Chief Complaint**Recommended Treatment**

- Physiotherapy*
- Chiropractic Care*
- Massage Therapy*
- Acupuncture*
- Naturopathic Medicine*
- Registered Dietitian*
- Laser Therapy*
- Shockwave Therapy*
- Custom Foot Orthotics*
- Orthopaedic Shoes*
- Compression Socks*
- Braces and Supports*
- TENS Machine*
- Other:*

Physician's Comments:**Medical Clinic's Stamp****Physician's Signature:**

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