



Patient's Name: _____

Patient's Address: _____

DOB: _____ Phone: _____

Patient's Chief Complaint

Recommended Treatment



- Head and Neck Pain
- Shoulder Pain
- Elbow, Arm and Hand Pain
- Back and Gluteal Pain
- Hip and Thigh Pain
- Knee Pain
- Leg, Ankle and Foot Pain

Other: _____

- 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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