



Attention you deserve...results you desire.

Thank you for choosing Active Motion for your Therapy needs.

Please take a moment to provide us with some basic personal information.

**Active Motion does not disclose any personal information to third parties without the prior consent of the client.**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Guardian Name (if under 18 yrs. old): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Prov: \_\_\_\_\_ Post Code: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_

E-Mail: \_\_\_\_\_ \* Used **exclusively** for correspondence with Active Motion

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Please indicate (with an 'x') if any of the following apply:

Diabetes  Heart Disease  Pacemaker  Pregnant

Other (Please Specify): \_\_\_\_\_

Area of concern (Injury): \_\_\_\_\_

Name of Health Care Providers involved in your care:

Family Physician: \_\_\_\_\_

Other Physicians/Surgeons: \_\_\_\_\_

Other Health Professionals: \_\_\_\_\_

Do you give Active Motion consent to discuss your care with the above professionals?

Yes  No

How did you hear about Active Motion ? \_\_\_\_\_

I understand that I am personally responsible for all treatment costs

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Please complete the drawings on PAGE 2**

1. Using a pen/pencil, please shade in on the bodies below to indicate all areas of pain, discomfort and concern. Feel free to add a brief text description.
2. Please indicate any old injuries (“O”), numbness (“N”), tingling (“T”) and burning (“B”) with the appropriate symbol on the drawings below.

