Alevia® Health and Wellness Centre™

Patient Number: _____

APPLICATION FOR TREATMENT

Name: _____ Date of Birth: MM/____ DD/____ YY/____ Sex: ☐M ☐F

Address: _____ City: _____ Province: _____ Postal Code: _____

Home Phone #: _____ Work Phone #: _____

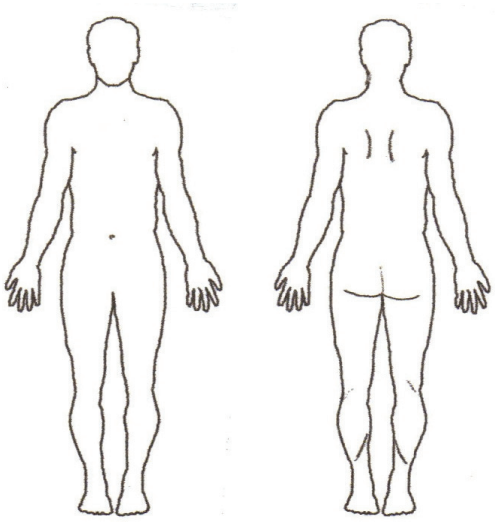
Occupation/Employer: _____ Spouses Name (If married): _____

Employer: _____ Spouses Employer: _____

Address: _____ Ages of Children (If any): _____

Emergency Contact: _____ **Phone #:** _____

Please print and circle areas of complaint below and on a scale of 1-10 (10 being the worst) rate your discomfort.



Major Complaint

Please describe your main problem briefly

When did you first notice this problem? _____

How did that problem begin? _____

Since that time, has it been (check one)

☐Getting Better ☐Getting Worse ☐Staying the Same

Have you seen a doctor for this condition? ☐Yes ☐No

If yes, Doctor Name and Phone #: _____

Have you lost time from work due to this condition? ☐Yes ☐No

If yes, from _____ to _____

Have you done anything for it that seems to help? _____

Have you ever been involved in an auto accident, sports injury, bad fall or other significant injury? _____

Do you have any known allergies (including medication)? _____

Have you ever been diagnosed as having or suffering from: (check all that apply)

☐ Osteoarthritis	☐ Eating Disorder	☐ Broken or fractured Bones	☐ Epilepsy	☐ Alcoholism
☐ Circulatory Problems	☐ Pacemaker	☐ Drug Addiction	☐ Rheumatoid Arthritis	☐ Stroke
☐ HIV Positive	☐ Seizures/Convulsions	☐ Cancer / Tumors	☐ Gall Bladder	☐ Ulcers
☐ Congenital Disease	☐ Diabetes Type I / II	☐ Excessive Bleeding	☐ Depression	☐ Smoking
☐ High/Low Blood Pressure	☐ Sprain/Strain	☐ Coughing Blood	☐ Other: _____	

All fees are payable at the time services are rendered unless other arrangements have been made. X-rays remain the property of this clinic

Patient's Signature: _____ Date: _____