THE ANNERGY CENTRE

CLIENT INFORMATION

Client's Name:____

Street Address:____ Apt.:__________

City:____________________ Province:________________ Postal Code:________________

Home Phone:__________________ Work Phone:__________________ Cell:________________

Fax #:_________________________ E-mail:____

Parent/Guardian Name(s) (if client is a child):______________________________________

Employer:____________________________________ Occupation:_________________________

Address:_____________________________________ Phone:______________________________

May we call you at work? ___YES ___NO Whom may we thank for referring you?___________________

EMERGENCY INFORMATION

In case of emergency, please contact: Name:_____________________ Phone:______________

Relationship:_________________

PERSONAL HISTORY

Date of Birth:_____________________ Name of Spouse/Partner:__________________________

Preferred Appointment Times:_____________________

MEDICAL INFORMATION

Medical Alerts:________________________

Allergies (e.g. latex):__________________________

Haemophilia__________________________________

Surgical Implants (e.g. artificial joint)________________

Family Physician:______________________

Address: ______________________

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Phone:_____________________________

Medical Specialists______________________

I understand that payment is expected on the day of each treatment. I am responsible for all charges, regardless of insurance coverage. I understand that all information will be held strictly confidential.