Client Demographic Information Sheet

Provider: ___________________

Today's Date: ______________________ Doctor's name on referral: ______________________

Last Name: _________________________ First Name(s): ______________________________

Preferred Name (if different from above): ____

❒Male ❒Female Date of Birth: D______ M______ Y_______

Local Address: ____

City: __________________ Postal Code: ___________ Home Phone: ___________________

Cell Phone: _______________________ Business Phone: _________________ ext. ______

Permanent Address *(if Different From Above)*: ____

City: __________________ Postal Code: ___________ Phone #: ______________________

Email: ____

Ontario Health Card Number: __________________________________ **Version:** _________

Expiry Date: D______ M______ Y______

Family Doctor: _________________________________ City: _________________________

Allergies: ____

Medical Problems: ____

Medications: ____

Emergency contact name: __________________________ **Relationship:** ____________________

Phone: ____________________________

How did you hear about WSM RIM Park? Please name the person where possible.

❒Doctor ____ ❒Phonebook/Ad

❒Coach/trainer/teammate/manager __________________ ❒Website

❒Family/friend/co-worker/teacher ___________________ ❒Walk-by in RIM Park

❒Clinician (PT, RMT, Chiro., etc.) __________________ ❒Other WSM Location