Alevia® Health and Wellness Centre™

1251 Huron Street, Unit 111
London, Ontario N5Y 4V1
Tel 519.453.7117 • Fax 519.453.6540

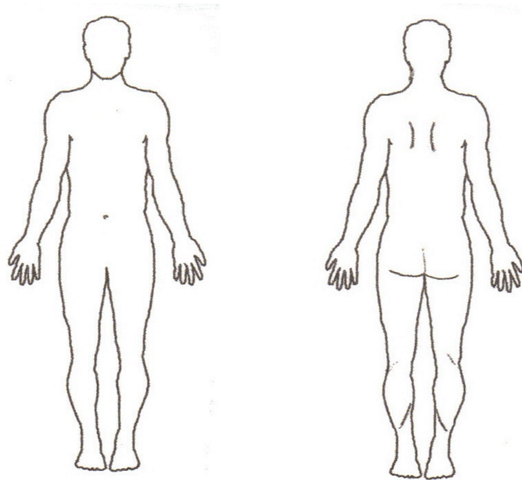
Patient Number: ____________________

# APPLICATION FOR TREATMENT

NAME: ______________________________ BIRTHDATE: ____________________ SEX: M/F
ADDRESS: ____________________ CITY: ____________ PROVINCE: ______ POSTAL CODE: __________
HOME PHONE: ______________________ WORK PHONE: ______________________

OCCUPATION: ______________________ SPOUSE'S NAME (IF MARRIED) ______________
EMPLOYER: ______________________ SPOUSE'S EMPLOYER: ______________
ADDRESS: ______________________________ AGES OF CHILDREN (IF ANY): __________
**EMERGENCY CONTACT**: ______________________ PHONE #: ______________

Please 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 (circle one)
Getting better / getting worse / staying the same
Have you seen a doctor for this condition? Yes/No
If Yes, Doctor name and number: ______________
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? If so, what? ______________________
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.

Signature: ______________________ Date: ______________