Oakville Trafalgar Memorial Hospital
327 Reynolds Street
Oakville, ON L6J 3L7
Tel: (905) 845.9540
Fax: (905) 815.5109

Milton District Hospital
7030 Derry Road
Milton, ON L9T 7H6
Tel: (905) 876.7022
Fax: (905) 876.7005

Georgetown Hospital
1 Princess Ann Dr.
Georgetown, ON L7G 2B8
Tel: (905) 873.4598
Fax: (905) 873.4567

❒ Dr. Henry Candelaria, BPHE, DC

All net proceeds support hospital programs.

Welcome, and thank you for choosing Work-Fit Total Therapy Centre. We offer quality professional health care. Direct and open communication between you and the staff is essential for proper care. Please complete the following form to ensure you receive the appropriate care.

Contact Information

□ Mr. □ Mrs. □ Miss □ Ms. □ Dr. □ Sir

Name: ____
First Name Last Name

Address: ____

City: ____________________ Province: _______ Postal Code:____________________

Phone #: Home: __________________Work: ________________ Cell: __________________

Email: ____________________________ Date of Birth: Day_____Month_____Year______

Gender: □ Male □ Female

Occupation: ____________________ Hrs/week: _______ Work posture: ________________

Emergency Contact Name: ______________________________ Phone #: ________________

Emergency Contact's Relationship to You: ____________________

Medical Information

Family Physician: ___________________________ Phone: (____)_______________________

Address: ____

City: _______________________Province: ________ Postal Code:_____________________

Previous Treatment:

□ Athletic Therapist □ Chiropractor □ Massage Therapist □ Acupuncturist □ Other

Name (or Clinic Name):_______________________ Date of Last Visit: __________________

How did you hear about us?

□ Bell Yellow Pages □ Other Yellow Pages □ Internet
□ Yellowpages.ca □ White Pages □ Website
□ Advertisement (Location):______________ □ Referral:________________
□ Walk In □ Other: ___________

Chief Complaint

Reason for this appointment? (Chief Complaint) ____

When did your condition begin? ____

Is this condition related to: □ Occupation □ Car Accident □ Fall □ Sports Injury □ Other

Has this condition occurred before: □ Yes □ No

Are you currently taking any medication for this condition?: □ Yes □ No

Have you seen a health care professional for this condition?: □ Yes □ No

If yes, who?: ____

When is your pain the worst? □ Morning □ Mid-day □ Evening □ All day

What aggravates your pain? ____

What relieves your pain? ____

Does the pain affect your work, family life or recreational activities? □ Yes □ No

Does this condition cause you anxiety, stress, and / or depression? □ Yes □ No

Have you had any advanced tests performed for this condition? *(X-Rays, CT, MRI, Nerve Conduction Study, Ultrasound etc…)*

□ Yes □ No If yes: Date: ________________ Testing type: _____________