



APPLE CREEK SPORTS MEDICINE CENTRE

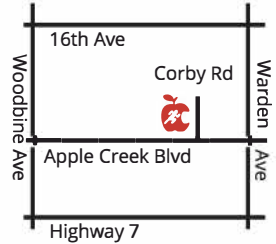
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PATIENT NAME _____

PHONE _____

DIAGNOSIS _____

TREATMENT _____



THERAPIST DISCRETION

- | | | |
|-------------------------------------|---|---|
| <input type="radio"/> ACUPUNCTURE | <input type="radio"/> INJURY REHABILITATION | <input type="radio"/> OSTEOPATHY |
| <input type="radio"/> CHIROPRACTIC | <input type="radio"/> ATHLETIC THERAPY | <input type="radio"/> CUSTOM BRACE |
| <input type="radio"/> PHYSIOTHERAPY | <input type="radio"/> MASSAGE THERAPY | <input type="radio"/> CONCUSSION MANAGEMENT |
| ORTHOTICS | | |

REFERRING PHYSICIAN _____

NOTES / COMMENTS / PRECAUTIONS _____

SIGNATURE _____

DATE _____