



APPLE CREEK

SPORTS MEDICINE CENTRE

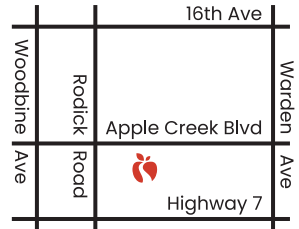
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PATIENT NAME _____

PHONE _____

DIAGNOSIS _____

TREATMENT _____



THERAPIST DISCRETION

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

REFERRING PHYSICIAN _____

NOTES / COMMENTS / PRECAUTIONS _____

SIGNATURE _____ DATE _____