THE ORTHOPAEDIC THERAPY CLINIC INC.

Patient Name:

Date of Birth: YYYY/MM/DD

Registered Physiotherapy

- ❍ Acupuncture
- ❍ Concussion
- ❍ Ergonomic Assessment
- ❍ Fracture/Trauma
- ❍ Osteoarthritis
- ❍ Osteoporosis
- ❍ Pelvic Floor Impairments
- ❍ Post-surgical/ arthroplasty
- ❍ Repetitive strain injury
- ❍ Rheumatoid arthritis
- ❍ Spinal rehabilitation
  - ❍ Degenerative
  - ❍ Scoliosis
  - ❍ Post-surgical
- ❍ Spondyloarthropathy/ AS (Ankylosing Spondylitis)
- ❍ Sports injury
- ❍ Therapeutic exercise
- ❍ TMJ
- ❍ Vertigo

Registered Chiropractic

- ❍ Functional medicine
- ❍ Manipulation
- ❍ Reiki

Registered Massage Therapy

- ❍ Acupuncture
- ❍ Craniosacral
- ❍ Manual lymph drainage
- ❍ Therapeutic massage
- ❍ Scar tissue massage

Registered Kinesiology

- ❍ Cancer care
  - ❍ Pre-hab
- ❍ Core conditioning
- ❍ Healthy aging
- ❍ Medical Exercise
- ❍ Return to sport recovery
- ❍ Return to work programs

From the office of:

Date: YYYY/MM/DD

Additional Notes

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