Patient Self- Referral Intake

Arthrosamid Knee Injections

Please complete the form below and send it to BC Joint Health.

Once received, our Clinic Director will contact you promptly.

If you have any questions, feel free to contact us:

📧 Email: info@bcjointhealth.ca

📞 Phone: 778-222-4362

Thank you for choosing BC Joint Health — we look forward to assisting you.

Patient Name: _____

Date of Birth: _____

Gender: _____

Street Address: _____

_____

City: _____

Province/State: _____

Postal Code/Zip Code: _____

Mobile Phone Number: _____

Home Phone Number: _____

Email Address: _____

Major Pain Complaint:

How did the pain occur? : _____

_____

_____

How long have you had this condition?: _____

_____

_____

Other pain complaint (s) : _____

_____

What makes it worse? _____

_____

What makes it better? _____

_____

Are you presently taking any prescription medication? Yes [ ] No [ ]

Are you presently taking non-prescription/ OTC medication? Yes [ ] No [ ]

Have you had any other treatments? _____

Do you have any allergies? _____

_____

What is your expectation regarding your knee pain? _____

_____

Have you had any recent x-ray's of your knee's? _____

How did you hear about Arthrosamid? _____

_____