Name:_____

Physiotherapy- Health History Questionnaire

Body part or area of symptoms: _____

_____

Date symptoms began: _____

Is this a work-related injury? _____

Is this injury related to a motor vehicle accident? _____

Family Physician: _____

Referred by: _____

How did you hear about our clinic? _____

Condition	**Yes**	**No**
Head Injury		
Digestive concerns		
Diabetes		
Seizures		
Lung disease		
Arthritis		
Heart attack		
Osteoporosis		
Allergies		
High/Low blood pressure		
Asthma		
HIV		
Hepatitis		
Stroke		
Blood clots		
Bleeding disorders		
Cancer		
Communicable disease		
Depression		
Anxiety		
Are you or may you be pregnant?		
Other		

Name:_____

Fee Schedule

Assessment and First Treatment	$120
Follow Up Treatment- Adult (30 min)	$90
Follow Up Treatment- Student (30 min)	$80
Follow Up Treatment (60 min)- Karen ONLY	$120
Gunn IMS / Dry Needling	$90
Shockwave Therapy	$90
MVA Assessment (Out of Protocol)	$150
MVA Treatment (Out of Protocol)	$90

If you **no show** for your appointment or **fail to cancel within 24 hours** you may be charged 50% of your appointment fee.

I have been made aware of the above fees and that payment is due at the time of service.

_____ _____

Patient/Guardian Signature Date

Name:_____

Physiotherapy Informed Consent Form

I consent to a physical assessment and treatment that may involve information gathering, active movement, observation, hands-on assessment, and may involve disrobing to some degree.

I will inform my physiotherapist of any infectious of contagious conditions I may have and I agree that I need to express all of my current and past health concerns to my therapist.

I consent to treatment that may involve the use of:

- Various thermal or electrophysical agents
- Intramuscular Stimulation which will require the use of needles placed into the muscle
- Hands-on manual therapy, manipulation, stretching and massage of joints and tissue.
- Exercise programs and education aimed at mobility, strength and function.

I understand that discomfort may occur during and after treatment. The therapist will contact my physician should the presence of symptoms represent any potential risk. I understand that it is my responsibility to contact the therapist should I experience any unusual symptoms.

I understand that if at any time I am not comfortable with and do not understand the purpose of any procedure that I will ask the physiotherapist for further explanation. I understand that I may revoke my consent at any time during or after the assessment or treatment without reason or explanation.

I have read, understood and had the opportunity to discuss the information on this form.

My signature below indicates my understanding of the above information.

Date: _____

Print name of client: _____

Signature of client: _____

Print name of witness: _____

Signature of witness: _____