



PHYSIOTHERAPY - INTAKE

HEALTH HISTORY QUESTIONNAIRE

Name: _____ DOB: _____

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? _____

Diabetes () Yes () No

Seizures () Yes () No

Lung Disease () Yes () No

Arthritis () Yes () No

Heart Attack () Yes () No

Osteoporosis () Yes () No

Allergies () Yes () No

High/Low Blood Pressure () Yes () No

Asthma () Yes () No

HIV () Yes () No

Hepatitis () Yes () No

Stroke () Yes () No

Blood clots () Yes () No

Bleeding disorders () Yes () No

Cancer () Yes () No

Communicable Disease () Yes () No

Depression () Yes () No

Are you or may you be pregnant? () Yes () No



PHYSIOTHERAPY - INTAKE FEE SCHEDULE

Name: _____ DOB: _____

	<u>Clinic Rate</u>	<u>Corporate Rate</u>
Assessment and first treatment	\$110	\$100
Treatment (one body part)	\$80	\$75
Treatment (two body parts)	\$100	\$90
Medical Acupuncture	\$70	\$60
Dry Needling	\$100	\$90
MVA assessment (Out of Protocol)	\$150	NA
MVA treatment (Out of Protocol)	\$90	NA

If you **do not show** for your appointment or **fail to cancel within 24 hours** you will 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.

Date

Name:

Signature:



PHYSIOTHERAPY - INTAKE

INFORMED CONSENT FORM

Name: _____ DOB: _____

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 or 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

Name:

Signature:

Witness Name:

Witness Signature: