PHYSIOTHERAPY – INTAKE
HEALTH HISTORY QUESTIONNAIRE

Name:_____DOB:(_____/_____/_____)
(dd/mm/yyyy)

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	HIV	( ) Yes	( ) No
Seizures	( ) Yes	( ) No	Hepatitis	( ) Yes	( ) No
Lung Disease	( ) Yes	( ) No	Stroke	( ) Yes	( ) No
Arthritis	( ) Yes	( ) No	Blood Clots	( ) Yes	( ) No
Heart Attack	( ) Yes	( ) No	Bleeding disorders	( ) Yes	( ) No
Osteoporosis	( ) Yes	( ) No	Cancer	( ) Yes	( ) No
Allergies	( ) Yes	( ) No	Communicable Disease	( ) Yes	( ) No
High/Low Blood Pressure	( ) Yes	( ) No	Depression	( ) Yes	( ) No
Asthma	( ) Yes	( ) No	Are you or may you be pregnant?	( ) Yes	( ) No

PHYSIOTHERAPY – INTAKE

FEE SCHEDULE

Name:_____DOB:(_____/_____/_____)
(dd/mm/yyyy)

	Clinic Rate
Assessment and first treatment	$110
Treatment (one body part)	$80
Treatment (two body parts)	$100
Medical Acupuncture	$70
Dry Needling	$100
MVA assessment (Out of Protocol)	$150
MVA treatment (Out of Protocol)	$110

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:(_____/_____/_____)
(dd/mm/yyyy)

I consent to a physical assessment and treatment that may invoice information gathering, active movement, observation, hands-on assessment, and may invoice 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 invoice the use of:**

- Various thermal of 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 procedures 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 or the above information.

Date: (_____/_____/_____)

Name:_____ Signature:_____

Witness name:_____ Witness Signature_____