**Physiotherapy For Health Clinic**

**Health History and Informed Consent**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate (MM/DD/YYYY)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Main Reason for Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate conditions you are experiencing, or have experienced:

**Respiratory** **Head and Neck** **Women**

\_\_Bronchitis \_\_Hearing Loss \_\_Pregnant

\_\_Asthma \_\_Vision Loss Due Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Emphysema \_\_Headaches

**Cardiovascular** **Other Medical Conditions** **Of Special Note**

\_\_Heart Disease \_\_Diabetes \_\_Internal Pins

\_\_High Blood Pressure \_\_Arthritis \_\_Wires

\_\_Pacemaker or Similar \_\_Cancer \_\_Artificial Joints

\_\_Heart Attack \_\_Allergies (Tape/Latex/Other) Please Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_HIV

\_\_Hepatitis

Current Medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Involvement in other Health Care? YES / NO

\_\_Chiropractor \_\_Naturopathic \_\_Acupuncture \_\_Massage

Is your injury the result of a motor vehicle accident? \_\_\_\_\_ If yes, Date of Accident \_\_\_\_\_\_\_\_\_\_\_\_\_

Is your injury the result of a work place injury? \_\_\_\_\_\_ If yes, Date of Accident\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Informed Consent

I understand that I can discontinue or change the proposed treatment at any time. I agree to inform my therapist of any discomfort I may experience during the physiotherapy treatment. The information I have given my therapist is confidential and will only be released to a third party with my written consent. I have read and understand the above information.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby give my consent to physiotherapy treatment.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*\*\*PLEASE BE ADVISED\*\*\****

***Patients will be charged $60.00 if 24 hours notice is not given to change or cancel your appointment.***