Physiotherapy For Health Clinic
Health History and Informed Consent

Name_____
Address_____
_____
Postal Code_____
Occupation_____

Phone Home_____
Phone Work_____
Birthdate (MM/DD/YYYY)_____
Email_____
Physician_____

Main Reason for Treatment_____

Please indicate conditions you are experiencing, or have experienced:

Respiratory
__Bronchitis
__Asthma
__Emphysema

Head and Neck
__Hearing Loss
__Vision Loss
__Headaches

Women
__Pregnant
Due Date_____

Cardiovascular
__Heart Disease
__High Blood Pressure
__Pacemaker or Similar
__Heart Attack

Other Medical Conditions
__Diabetes
__Arthritis
__Cancer
__Allergies (Tape/Latex/Other)
__HIV
__Hepatitis

Of Special Note
__Internal Pins
__Wires
__Artificial Joints
Please Specify_____

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.