ENDURANCE 8 PHYSIOTHERAPY INTAKE FORM

CLIENT INFORMATION:

1. What is your primary complaint (or body 2. Do you presently or have you ever had a Pacemaker A Heart Problems F High Cholesterol C Stroke F Lung Problems 7 Cancer S Diabetes F High Blood Pressure F	City City Massage Therapis Sign y part) that you are see ny of the following? Ch rthritis	(C): Phone: _ Phone: _ st Ph Ot eking trea	hysiotherapist her tment for today?
Email:	nd Massage Therapis Sign y part) that you are see ny of the following? Ch	(C): Phone: _ Phone: _ st Ph Ot eking trea	hysiotherapist her tment for today?
Phone (H):	nd Massage Therapis Sign y part) that you are see ny of the following? Ch rthritis	(C): Phone: _ Phone: _ st Ph Ot eking trea	hysiotherapist ther tment for today?
Emergency Contact: Family Physician: Referred by: (Circle One) Family / Fri Doctor Phone Book HEALTH HISTORY 1. What is your primary complaint (or book 2. Do you presently or have you ever had at Pacemaker Heart Problems High Cholesterol Stroke Lung Problems Diabetes Diabetes High Blood Pressure	nd Massage Therapis Sign y part) that you are see ny of the following? Ch rthritis	Phone: _ Phone: _ st Ph Ot eking trea	hysiotherapist her tment for today? at apply.
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Family Physician:	nd Massage Therapis Sign y part) that you are see ny of the following? Ch rthritis	Phone:	hysiotherapist her tment for today? at apply.
Referred by: (Circle One) Family / Fri Doctor Phone Book HEALTH HISTORY Phone Book 1. What is your primary complaint (or book Pacemaker 2. Do you presently or have you ever had a Pacemaker Heart Problems H High Cholesterol O Stroke F Lung Problems T Osteoporosis/Osteopenia A High Blood Pressure E	nd Massage Therapis Sign y part) that you are see ny of the following? Ch rthritis	st Pr Ot eking trea neck all th	nysiotherapist her tment for today? at apply.
Doctor Phone Book HEALTH HISTORY 1. What is your primary complaint (or boo 2. Do you presently or have you ever had a Pacemaker 4 Heart Problems 4 High Cholesterol 6 Stroke 4 Lung Problems 7 Cancer 5 Diabetes 7 Osteoporosis/Osteopenia 4 High Blood Pressure 6	Massage Therapis Sign y part) that you are see ny of the following? Ch rthritis	st Ph Ot eking trea neck all th	nysiotherapist her tment for today? at apply.
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PacemakerAHeart ProblemsHHigh CholesterolCStrokeFLung ProblemsTCancerSDiabetesFOsteoporosis/OsteopeniaAHigh Blood PressureF	rthritis		
	IV / AIDS nronic Fatigue epeated Infections hyroid Problems kin Disease/Sensitivity epression sthma pilepsy/Seizures nxiety	□ □ 1 □	Liver Disease (Fatty Live Parkinson's Disease Multiple Sclerosis Allergies ADHD Other
3. Please provide a list of any surgeries, m	jor traumas, or car acc	cidents:	
4. Please provide a list of your current me			

Signature:_____

Date: _____

ENDURANCE 8

INFORMED CONSENT TO PHYSIOTHERAPY TREATMENT/ASSESSMENT

I hereby authorize and grant permission to Endurance on 8th Health Centre's Mobile Physiotherapist to carry out any assessment and examination, procedure, and treatments as may be necessary to assess and treat my condition or injury. (please initial _____)

The Mobile Physiotherapist agrees to provide me with understandable information on:

- My diagnosis, as known
- The treatment being suggested
- Significant risks, benefits of treatment, and possible alternatives to this treatment •
- Reasonable additional procedures which may be necessary •
- The potential risks of foregoing the suggested care •

(please initial _____)

I hereby authorize and grant permission to the Mobile Physiotherapist to communicate with any health care professional that rehabilitation of my condition may indicate

(please initial _____)

I hereby authorize and grant permission to the Mobile Physiotherapist to release information regarding my condition and my ability to return to normal activity or work to my insurance company/employer/lawyer or their representative (please initial _____)

I agree that email correspondence may occur with Endurance on 8th Health Centre and will hold Endurance on 8th Health Centre free of all liability for any actions/results/adverse situations created as a result of such correspondence. (please initial _____)

I understand that 24 hours notice for any change or cancellation to my appointment is required. Endurance on 8th Health Centre reserves the right to charge 50% of the regular fee for any missed or cancelled appointments with less than 24 hours advance notice. (please initial _____)

understand the conditions and information as verbally provided and I, voluntarily give my consent to the above authorizations.

Patient Signature:	Date:
Witness:	Date:
Mobile Physiotherapist:	Date:
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