PHYSIOTHERAPY INTAKE FORM

CLIENT INFORMATION:

Name: _____ DOB (MM/DD/YYYY): _____

Address: _____
Street City Postal Code

Email: _____ AHC: _____

Phone (H): _____ (W): _____ (C): _____

Emergency Contact: _____ Phone: _____

Family Physician: _____ Phone: _____

Referred by: (Circle One) Family / Friend _____

Doctor Massage Therapist Physiotherapist

Phone Book Sign Other

HEALTH HISTORY

1. What is your primary complaint (or body part) that you are seeking treatment for today?

_____

2. Do you presently or have you ever had any of the following? Check all that apply.

- ☐ Pacemaker
- ☐ Heart Problems
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Lung Problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Osteoporosis/Osteopenia
- ☐ High Blood Pressure
- ☐ Currently Pregnant
- ☐ Arthritis
- ☐ HIV / AIDS
- ☐ Chronic Fatigue
- ☐ Repeated Infections
- ☐ Thyroid Problems
- ☐ Skin Disease/Sensitivity
- ☐ Depression
- ☐ Asthma
- ☐ Epilepsy/Seizures
- ☐ Anxiety
- ☐ Viral Hepatitis
- ☐ Liver Disease (Fatty Liver)
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Allergies
- ☐ ADHD
- ☐ Other _____
  _____
  _____
  _____

3. Please provide a list of any surgeries, major traumas, or car accidents:

_____

_____

4. Please provide a list of your current medications:

_____

_____

Date: _____ *Signature:* _____

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 _____)

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

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Mobile Physiotherapist: _____ Date: _____