CENTER FOR HEALTHY LIVING

HEALTH HISTORY FORM

Last Name:_____ First Name:_____

Address:_____ City/Province/Postal:_____

Email:_____ Sex: M / F

Home: (____)_____ Work: (____)_____ Cell: (____) _____

Occupation: _____ _____( )_____

Emergency Contact + Number

DOB:(mm/dd/yyyy)_____

Name of Family/Critical care doctor: _____

Name of Insurance Provider: _____

Who may we thank for referring you to our clinic? _____

Medical History

□ Angina
□ Cancer
□ Cardiac Pacemaker
□ Any other heart problems (past or present)
□ Ostearthrisis
□ Osteoporosis
□ Pregnant
□ Radiotherapy/Chemotherapy (in past 6 months)
□ Steroids
□ Surgery
□ Blood thining medications
□ Weight Loss (sudden, >10lb)
□ Change in bowel/bladder function

Other Symptoms

□ Abdominal Pain
□ Accident
□ Allergies
□ Anxiety
□ Arthritis
□ Broken Bones
□ Circulatory/Vascular Disease
□ Decreased range of motion
□ Diabetes
□ Disk Problem
□ Headaches
□ High blood pressure
□ Joint Ache
□ TMJ Problems
□ Low Back Pain
□ Mid Back Pain
□ Upper Back Pain
□ Medications Y / N
□ Menstrual
□ Neck Pain
□ Nervous Tension
□ Numbness/Tingling
□ Sciatica
□ Sleep disturbances
□ Sprains
□ Skin Conditions: _____
□ Varicose Veins
□ Whiplash

List of Medication: _____

_____

In regards to your current condition:

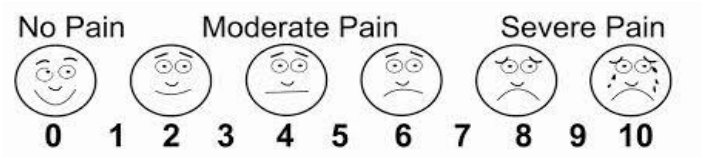
Are you experiencing any pain at the moment? Y / N

If you answered "Yes", What is your main complaint & symptoms: _____

_____

_____

Pain Scale: How servere are your symptoms out of 10?



Physical Activities

□ Running □ Walking □ Sports □ Biking □ Gym □ Swimming □ Yoga □ Other

Other : _____

CENTER FOR HEALTHY LIVING

PHYSIOTHERAPY CONSENT FORM

CONSENT FOR ASSESSMENT & TREATMENT

I hereby consent to the assessment and treatment performed by the Registered Physiotherapist named below. I understand that my treatment plan will be discussed with me and treatment may include, but not limited to: education, electrotherapy, manual therapy, manipulation, acupuncture, intramuscular stimulation (IMS), and exercise. I understand that I should discuss any questions or concerns about my treatment with my physiotherapist and I have the right to decline any portion of the treatment at any time.

I understand that there are benefits and risks involved with physiotherapy treatment and that the response to treatment varies and cannot always be predicted as every individual is different. There is a risk that treatment will cause some discomfort or aggravations of the existing condition.

CONSENT FOR COMMUNICATION/RELEASE OF INFORMATION

I understand that the clinical information gathered during the course of my treatment may be necessary to communicate with others involved in my medical care, such as doctors, insurers, and other healthcare practitioners. I authorise my physiotherapist named below to communicate with and release information concerning my medical care.

CANCELLATION & NO SHOW POLICY

Cancellations must be made a minimum of 24 hours prior to appointment. I agree to pay in full, charges for missed appointments or cancellations made less than 24 hours' notice.

I have read the above consent, and I have the opportunity to ask questions about its content. This consent will cover the physiotherapy assessment and entire course of treatment.

_____ _____

Patient's Name (please print) Physiotherapist Name (Please print)

_____ _____

Signature of Patient Date Signed