Personal information

Please complete the following questionnaire. Your answers will help us to determine if physiotherapy can help you.

All your answers will be considered confidential. No information will be released without your consent. Thank you!

First Name: ..... Middle name: ..... Last name: .....

Date of Birth (dd/mm/yy): ..... Age: ..... Gender: □Male □Female □Other □Prefer not to say

Address: ..... City/Province: ..... Postal Code: .....

Home phone #: ..... Cell #: ..... AHC #: .....

email (Please PRINT): ..... work #: .....

Occupation: ..... Employer/School: .....

Emergency Contact First/Last Name: .....

Emergency Contact #: ..... Relation: .....

Family Physician First/Last Name: ..... Contact #: .....

Referring Physician (if not same as above): ..... Contact #: .....

Area of injury: ..... Date of Injury/Accident: .....

Is your injury related to a recent Motor Vehicle Accident? □Yes □No

Is your injury related to work? □Yes □No

Are you seeking treatment after a fracture or a surgery? □Yes □No

Health information

How would you describe your general health status? □Good □Poor

Reason for seeking treatment today: .....

Have you received treatment before? □Yes □No

If yes, what injury and when? .....

Please list any medication you are currently taking and reason for taking them: .....

.....

.....

Please list your past surgeries with dates: .....

.....

Please list your allergies: .....

Life habits: use of □Smoking □Alcohol □Drugs □Marijuana

Are you receiving treatment from other health care professionals? □Yes □No

If yes, who and what is it for: .....

.....

Female clients: Is there a chance that you could be pregnant? □Yes □No If yes, due date: .....

Please check if you presently have or have had any of the following conditions. Mention details when appropriate.

□ Double vision	□ Heart disease	□ Respiratory condition	□ Thyroid disorder	□ Neck pain
□ Blurring of vision	□ Heart attack	□ Asthma	□ HIV	□ TMJ pain
□ Dizziness / Vertigo	□ High blood pressure	□ Bronchitis	□ Hepatitis	□ Upper back pain
□ Headaches	□ Low blood pressure	□ Constipation	□ Herpes	□ Low back pain
□ sensitivity to light	□ Diabetes	□ Diarrhea	□ Tuberculosis	□ Osteoporosis
□ sensitivity to noise	□ Aneurysm	□ Stomach ulcer	□ Frequent/painful urination	□ Osteoarthritis ....
□ Stroke / CVA	□ Varicose veins	□ Hiatus hernia	□ Liver/Gallbladder disease	□ Tendonitis .....
□ Numbness or tingling:	□ Heartburn	□ Mental health issues	□ Sinusitis	□ Hip pain
□ Nervous system disorders:	□ Chest pains	□ Anxiety	□ Sleep disorders	□ Knee pain
□ Weight loss	□ Cancer:	□ Depression	□ Insomnia	□ Ankle/foot pain
□ Night fever/sweats	□ hearing loss	□ Epilepsy	□ Menstrual problems	□ Shoulder pain
□ Ringing in ears	□ vision loss	□ balance problem	□ pelvic floor pain	□Elbow pain
□ head trauma	□ falls / near falls	□ Metal Implants	□ Kidney/bladder disease	□ Wrist/hand pain
□ Other:				

Please explain if there is a family history of above mentioned conditions: .....

.....

Patient Signature: .....

Date: .....dd..... / .....mm..... / .....yy.....

Witness Signature: .....

Date: .....dd..... / .....mm..... / .....yy.....

INFORMED CONSENT TO PHYSIOTHERAPY ASSESSMENT AND TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your physiotherapist and to make an informed decision about proceeding with treatment. Physiotherapy may include, but is not limited to, manual therapy including spinal manipulation, use of electrical stimulation and other modalities, dry needling, education and exercise. Your treatment program will be designed by your physiotherapist however a physiotherapist assistant may also be involved in your care. Your physiotherapist will explain the benefits, alternative options and potential risks of each modality. Please ask your therapist in case you have any questions or concerns about any of the modalities that are chosen for your treatment. You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to your physiotherapist's attention. If you are not comfortable at any point during your treatment or if you choose not to participate in any aspect of the treatment, you must inform your physiotherapist right away.

It is your right to withdraw your consent at any point during the treatment. If you choose to do so, please inform your physiotherapist of your decision immediately. Please be involved in and responsible for your care. Inform your physiotherapist immediately of any changes in your condition.

I hereby acknowledge that I understand and agree with the above criteria and therefore consent to participate in an assessment and treatment.

Patient's name (Please print): .....

Patient Signature: ..... Witness Signature: .....

Date: .....yy..... / .....mm..... / .....dd..... Date: .....yy..... / .....mm..... / .....dd.....