PHYSIOTHERAPY CONSULTATION ADMITTANCE FORM

First Name: _____ Last Name :_____ Nickname:_____

Address: _____City:_____ Postal Code: _____

Home#: (____)_____-_____Work#: (____)_____-_____Cell# (____)_____-_____

Age:____ Birth Date: _____Sex: Male / Female Height: _____ Weight:_____
DD-MM-YYYY

Alberta Health Care#:_____-_____ Referred to this office by:_____

Extended Health Care: _____
Name of insurance Group-Policy# Cert/ ID#

Occupation: _____ Email: _____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE.

Reason for Appointment?_____

When did your condition begin?_____

Have you ever had similar problems? _____Yes _____No

Have you had X-rays, MRI or other tests for this condition? What tests and When?_____

_____

Is this condition related to: Work? ___Yes ___No Date of injury:_____

Do you have any metal implanted in your body? _____ Yes _____No

Are you or might you be pregnant? ____Yes _____No

Do you have a pacemaker? ____Yes ____No

Describe your stress level: ___None ___Mild ___Moderate ___High

Please list any previous surgeries, illnesses, injuries (motor vehicle accident):_____

_____

Have you had previous physiotherapy care?____Yes____No Date: _____

Family doctor name: _____

List all medications: (prescriptions, vitamins, herbal supports, BCP, aspirin, etc.)_____

_____

Date: (DD-MM-YYYY) _____ Patient Signature:_____

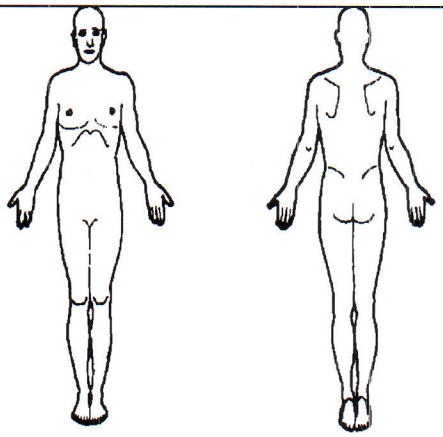
HEALTH HISTORY QUESTIONNAIRE

Name:_____

Have you ever been diagnosed or told you have any of the following?
Please circle the correct response.

1.	High blood pressure.....	Yes	No
2.	Hardening of the arteries (arteriosclerosis).....	Yes	No
3.	Diabetes.....	Yes	No
4.	Tuberculosis.....	Yes	No
5.	Cancer, Where?	Yes	No
6.	Heart or blood diseases.....	Yes	No
7.	Bone spurs on the neck bones (cervical sprain).....	Yes	No
8.	Whiplash injury (flexion-extension injury, cervical sprain).....	Yes	No
9.	Have you or any of your relatives ever suffered a stroke?	Yes	No
10.	Were you ever a smoker? From_____ To_____	Yes	No
11.	Do you take any medication on a regular basis?.....	Yes	No
12.	Visual disturbances (blurring, loss, double)	Yes	No
13.	Hearing disturbances (loss, ringing, other noise).....	Yes	No
14.	Slurred speech or other speech problems.....	Yes	No
15.	Difficulty swallowing.....	Yes	No
16.	Dizziness.....	Yes	No
17.	Loss of consciousness, even momentary blackouts.....	Yes	No
18.	Numbness, loss of sensation, strength or weakness in the face, fingers hands, arms, legs or any other parts of the body.....	Yes	No
19.	Sudden collapse without loss of consciousness.....	Yes	No

Indicate the location of your pain by shading in the appropriate area



Indicate the severity of the pain by circling a number.

0	1	2	3	4	5	6	7	8	9	10

No Pain Extreme Pain

INFORMED CONSENT FOR PHYSICAL THERAPY

Dear Patient,

Physical therapy involves the use of many different types of physical evaluation and treatment. At Windermere Chiropractor & Physiotherapy Clinic, we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical responses to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

I acknowledge that my treatment program has been explained by Windermere Chiropractor & Physiotherapy Clinic, and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of Physical Therapy as outlined to me, and I wish to proceed.

_____	_____	_____
Patient Name	Patient Signature	Date (DD-MM-YYYY)

Physiotherapy Treatment Waiver & Release of Liability

I have volunteered to participate in a program of health care (physical therapy) and to retain the services of Windermere Chiropractor & Physiotherapy Clinic and it's independent contractor to receive said services. I intend to assume all risk of injury from my participation. To that end, I acknowledge and agree to all of the following:

1. The treatment may include but is not limited to one or more of the following: evaluation, manual therapy, joint mobilization, soft tissue mobilization, therapeutic exercise, neuromuscular re-education, therapeutic activities, and modalities including but not limited to ultrasound, electrical stimulation, and hot and cold packs. There are inherent risks involved in any evaluation and treatment program. It is not possible to guarantee or give assurance of a successful result. It is important that you understand and agree to the planned treatment. Physical Therapy is generally safe and helpful. However, medical procedures of any type involve the taking of risks, ranging from minor to serious (including the risk of death). It is important to be aware of the following risks before you receive the treatment you and your health care provider are planning.

2. The possible benefits of this treatment include: decreasing pain, improving cardiovascular fitness, muscle strength, endurance, flexibility, improved body posture, movement and alignment. During treatment there exists a potential for numerous side effects including but not limited to muscle soreness or stiffness; numbness, tingling, or other parasthesias; muscle tears; bony fractures; paralysis; abnormal blood pressure, cerebrovascular accidents, fainting, disorders of heartbeat, and instances of heart attack and death. I assume all of the foregoing risks, and accept personal responsibility for any other damages or other injury I might suffer. I am satisfied with my understanding of the more common risks and complications of the evaluation and treatment.

3. I know I have the right to choose what treatment I do or do not receive in addition to withdrawing from any treatment at any time.

4. I understand that a physician's examination and approval should be obtained prior to participation in a health care program.

5. I recognize that my participation in the activity covered hereby is conditioned upon my signing and returning this waiver and release. I understand that I may show this INFORMED CONSENT and WAIVER & RELEASE OF LIABILITY to, and consult with, my own independent legal counsel before signing.

6. I have read and understood this INFORMED CONSENT and WAIVER & RELEASE OF LIABILITY and it accurately sets forth my intentions and I agree to be bound by its provisions.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

(DD-MM-YYYY)