Shifra Centre for Wellness- Physiotherapy Intake Form

Vanessa Hagen, BScPT., BKin.

Name: ______________________________

Personal Health Number: _________________________

Address: ____

City Province Postal Code

Employer: ______________________ Occupation: ______________________

Home Phone: _______________________ Cell: ______________________

Date of Birth: MM/DD/YR ______________________ Age: ____________

Email: ___________________________

Family Physician: ____________________

Other health care providers: ____

General health questions

Any previous injuries? (motor vehicle accidents, sports related accidents, falls etc)

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Please list any medical issues/conditions

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Please list any medications, vitamins that you currently taking

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How can I help you improve your overall health? What are your goals?

____

Payment is due at the time of the appointment: important information about no shows and late cancellations below.

Please remember that each appointment time is reserved especially for you. Please be considerate when changing appointments by allowing a minimum of 24 hours notice prior to cancellations.

We do process a cancellation fee for no shows or cancellations made last minute.   The charge for will be half the appointment for the first missed appointment and the full fee for the subsequent missed appointment.   Of course we know that there are unforeseen circumstances in life and this will be considered. Thank you for your understanding!

We ask that you sign below in acknowledgement and understanding of your liability of any costs incurred by you at this clinic:

Signature:_____________________________________   Date: _________________________

INFORMED CONSENT TO PHYSICAL THERAPY

I request and consent to the performance of a physical assessment and treatment on me by the Physical Therapist.

I have had the opportunity to discuss with the Physical Therapist the nature and purpose of the physical therapy treatment and other procedures. I understand that results are not guaranteed. I further understand and informed that, as in all health care, in practice of physical therapy there are some risks to treatment, including, but not limited to: muscle strains, sprains and increased soreness. I do not expect the Physical Therapist to be able to anticipate and explain all risks and complications and I wish to rely on the Physical Therapist to exercise judgement during the course of the procedures which the Physical Therapist feels at this time, based on upon the faces then known, are in my best interest.

I have read the above consent. I have had the opportunity to ask questions about its content, and by signing below I agree to the above mentioned Physical Therapist procedures.

I intend this consent form to cover my current and future treatments. I understand that I have the right to withdraw my consent at any time.

Patient’s Name: ____________________________________

Patient’s (or parent/guardian) signature: ___________________________

Date: ____________________________________