Balanced Health and Sports Therapy

Chiro ● Physio ● Massage

PHYSIOTHERAPY INTAKE FORM

Personal Information:

Name: _____ Date: (d/m/y) _____
Address: _____
City/Province: _____ Postal Code: _____
Telephone: Home: _____ Cell: _____
Work: _____ E-mail: _____
Please mark if you would like to receive our monthly newsletter: ☐ Yes ☐ No
Date of Birth (d/m/y): _____ Age: _____ Sex: _____
Occupation: _____ PHN: _____
Emergency Contact Information: _____
How did you hear about the Balanced Health and Sports Therapy: _____

Health Information:

Why have you come for physiotherapy: _____
Are you receiving other treatments: ☐ Yes ☐ No
If Yes With whom: _____ For what condition: _____
Date of last treatment: _____ Date of last x-ray: _____ Where: _____
List surgeries and dates: _____
Name of medical doctor: _____ Phone: _____
List current medications and dosage: _____
_____
Do you smoke: ☐ Yes ☐ No If Yes How long: _____ How many per day: _____
If female are you pregnant: ☐ Yes ☐ No Term: _____
In your family is there a history of cardiovascular problems ie: heart attack, stroke; high blood pressure or diabetes: ☐ Yes ☐ No
What, if any, fractures or dislocations have you had and when: _____
_____
List any motor vehicle accidents you have been in and when they occurred: _____
_____
Any allergies to tape: ☐ Yes ☐ No Do you have sensitive skin: ☐ Yes ☐ No
Is there anything else about your health we should know? _____
_____
Can your medical doctor be contacted with treatment updates: ☐ Yes ☐ No

If this is a WCB related issue, our clinic is WCB approved for Chiropractic only.

Alberta Health Services **DOES NOT** cover physiotherapy treatments, initial appointments are charged an assessment fee of $85.00 and subsequent visits are $70.00. We encourage you to inquire about possible coverage through your Extended Health Insurance, should it be available.

I hereby acknowledge and understand my liability for any cost incurred by myself at this clinic. I authorize and grant permission to my physiotherapist to carry out such examinations, procedures and treatments as deemed necessary.

Information will not be released to others without an Authority to Release Records and Information form signed by the patient.

_____ _____

1519 – 19th Street, Calgary, AB T2N 2K2
Phone: (403) 282-0880 Fax: (403)282-0898

Signature of patient (or parent/guardian) Date (d/m/y)

Informed Consent for Acupuncture Care

Please Read Carefully

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, and including moxibustion, cupping, and/or electoacupunture by physiotherapy.

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including but not limited to minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

I do not expect the physiotherapist to be able to anticipate and explain all possible risks and complications. I wish to rely on the physiotherapist to be able to exercise judgment during the course of the treatment which the physiotherapist feels at the time, based upon the facts then known, and is in my best interests. I understand that the results are not guaranteed.

I have read the above consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment. I also understand that I can refuse acupuncture treatment at any time.

N.B Female Patients:
I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

READ BEFORE SIGNING

_____	_____	_____
Date Signed	Print Patients Name	Signature of patient (or parent/guardian)