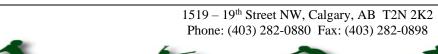
Balanced Health and Sports Therapy Chiro • Physio • Massage

PHYSIOTHERAPY INTAKE FORM

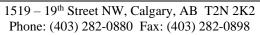
Personal Information:					
Personal Information:		Date:			
First Name:	Last Name:				
Address:					
City/Province: Telephone: Home:	Postal Code:				
Telephone: Home:	Cell:	Work:			
E-mail: Date of Birth (DD/MM/YYYY):	Alberta Health Care Numb	oer:			
Date of Birth (DD/MM/YYYY):	Age:	Sex:			
Occupation:					
Please check what type of reminder yo Emergency Contact Information: Name	ou would prefer: Email Reminder: e:	: Phone Call: None: one:			
Emergency Contact Information: Name How did you hear about the Balanced I	Health and Sports Therapy?				
Please note our cancellation policy	EASE READ THOUROUGHLY AND SIGN WHERE INDICATED BELOW r cancellation policy: If less than 24 hours' notice is given to cancel your appointment, will be charged the full price of the appointment.				
I UNDERSTAND THAT I WILL B APPOINTMENTS OR CANCELLATIO	E CHARGED THE FULL AF NS WITHOUT 24 HOURS NOTI	PPOINTMENT FEE ON ALL MISSED CE.			
SIGNATURE of Patient (or parent/gu	ardian)	DATE			
If this is a WCB related Alberta Health Services DOES NOT coassessment fee of \$100.00 and subsection overage through your Extended Healt	quent visits are \$80.00. We enco	nitial appointments are charged an ourage you to inquire about possible			
		by myself at this clinic. I authorize and procedures and treatments as deemed			
Information will not be released to o	others without an Authority to I signed by the patient.	Release Records and Information form			
Signature of patient (or parent/gu	uardian)	Date (d/m/y)			
digitatore of patient (of pareint ge	acidiany	Date (diffility)			





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Health Information:	physiathoropy?	
	physiotherapy?treatments: ☐ Yes ☐ No	
If Yes With whom:	ireatments. Tes Tivo	For what condition:
Date of last treatment:	Date of last	For what condition: Where: Where:
List surgeries and dates	:	
Name of medical doctor	:	Phone:
List current medications	and dosage:	
	•	
		How many per day:
In your family is there a	history of cardiovascular probl	ems i.e. heart attack, stroke; high blood
pressure or diabetes:	∃Yes □ No	, , ,
		d when:
List any motor vehicle a	ccidents you have been in and	when they occurred:
]Yes	nsitive skin: Yes No
Can your medical docto	r be contacted with treatment u	updates:Yes No
	Informed Consent	for Acupuncture Care
		supuncture and other procedures related to acupuncture, d/or electroacupuncture by physiotherapy.
but not limited to minor		cupuncture there are some risks to treatment, including n or soreness, nausea, fainting, infection, shock, and stuck or bent needles.
I have been advised that of after each and every		Il be used. All acupuncture needles are properly disposed
wish to rely on the phys	otherapist to be able to exercition the tacts	pate and explain all possible risks and complications. I se judgment during the treatment which the then known, and is in my best interests. I understand that
signing below I agree to	the above-mentioned acupun nt for my present and future co	n opportunity to ask questions about its content, and by cture procedures. I intend this consent form to cover the onditions for which I seek treatment. I also understand that
		of causing fetal distress with acupuncture treatment(s) is here any possibility that I may be pregnant.
Date Signed	Print Patients Name	Signature of patient (or parent/guardian)













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Chiropractic and Physiotherapy Authorization to obtain medical records.

To: (record h	nolder – completed by office)	
any and all limitation all progress not and medical	HEALTH AND SPORTS THERAPY information they may so require in relational plain film radiographs including xetes, nurses notes, reports on diagnost opinions and/or any other knowledge	nditionally authorize you to release to or anyone they shall in writing designate, elation to my health, including, but without ray films, radiology reports, clinical and c test, secondary assessment, chiropractic, information or data which you possess or ow this to be your complete and sufficient
privilege I nrelease and	nay have regarding secrecy of chiro	n to my doctor, I hereby waive any patient practic and medical information and I do or successors of and from all claims for any ation.
Date:		
Signature:	Patient (or parent/guardian)	_
Witness:	Signature	<u> </u>
Witness:	Name	











Balanced Health and Sports Therapy

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Informed Consent & Questionnaire for Laser Therapy

Please answer the following questions and read the statements below concerning High Power Class IV K-Laser® (Infrared) Therapy. If you have any questions, please speak with your clinician.

1. Is there any chance that you may be pregnant?	Y	N	
2. Do you currently have (or have a history of) cancer?	Y	N	
3. Do you have a family history of cancer?	Y	N	
Please list:			
4. Do you have a pacemaker or electronic implant?	Y	N	
5. Are you taking any blood thinners (ex. Aspirin)?	Y	N	
6. Do you have very light sensitive skin (Photosensitive)?	Y	N	
7. Do you currently have any infections/fever?	Y	N	
8. Do you have Heart or Kidney disease?	Y	N	
9. Are you taking any of the following medications (please circle):	Y	N	
Antihistamine, Coal Tar and derivatives, Antifungals,			
Contraceptives (birth control), Phenothiazines, Psoralens, Co	rticostero	ids, Cortis	one
Sulfonamides, Sulfonylureas, Thiazide Diuretics (water pills)), Tetracy	clines, Tri	cyclic
Antidepressants, High dose Vitamin A (ie. Accutane), Immun	nosuppres	sant drugs	3

Laser Therapy is a safe and effective therapy that is Health Canada cleared for the treatment of muscle and joint-related pain. Laser promotes the relaxation of spasm spasm/tension and promotes both increased tissues energy production and vasodilatation. Adverse effects from laser therapy are normally rare and temporary.

Pain relief from laser therapy may be dramatic and substantial, lasting for hours, days or weeks; however, your specific results may vary. Adverse effects from laser therapy may occur from multiple sources, in most cases involving a hypersensitivity to light, preexisting medical condition, thermal effects, excessive pressure from the treatment probe and laser over-stimulation. Laser therapy can cause serious damage to the eye, therefore it is very important to wear the protective glasses that will be provided at all times during treatment. Although rare, the most common adverse effects to laser therapy are:

- 1. Temporary increase in pain during laser application
- 2. Temporary increase in pain in the following day after laser therapy
- 3. Mild bruising
- 4. Temporary dizziness
- 5. Reactions when photosensitizing drugs are used with laser therapy

Your clinician has been thoroughly trained and certified to identify and minimize risk of any adverse reaction.

I have read and understand the potential risk associated with Laser Therapy and agree to the treatment program outlined by my clinician.

te Signed	Patient Name	Patient Signature

