Balanced Health and Sports Therapy

Chiro ● Physio ● Massage

PHYSIOTHERAPY INTAKE FORM

Personal Information:

Personal Information: Date: _____

First Name: _____ Last Name: _____

Address: _____

City/Province: _____ Postal Code: _____

Telephone: Home:_____ Cell: _____Work:_____

E-mail: _____ Alberta Health Care Number:_____

Date of Birth (DD/MM/YYYY): _____ Age: _____ Sex: _____

Occupation: _____

Please check what type of reminder you would prefer: Email Reminder: ☐ Phone Call: ☐ None: ☐

Emergency Contact Information: Name: _____ Phone: _____

How did you hear about the Balanced Health and Sports Therapy? _____

PLEASE READ THOUROUGHLY AND SIGN WHERE INDICATED BELOW

Please note our cancellation policy: If less than 24 hours' notice is given to cancel your appointment, your account will be charged the full price of the appointment.

I UNDERSTAND THAT I WILL BE CHARGED THE FULL APPOINTMENT FEE ON ALL MISSED APPOINTMENTS OR CANCELLATIONS WITHOUT 24 HOURS NOTICE.

_____ _____

SIGNATURE of Patient (or parent/guardian) **DATE**

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 $100.00 and subsequent visits are $80.00. 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.

_____ _____

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

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

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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 i.e. 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

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 electroacupuncture 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 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.

_____	_____	_____
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 holder – completed by office)

_____

I, _____, do unconditionally authorize you to release to BALANCED HEALTH AND SPORTS THERAPY or anyone they shall in writing designate, any and all information they may so require in relation to my health, including, but without limitation all plain film radiographs including x-ray films, radiology reports, clinical and progress notes, nurses notes, reports on diagnostic test, secondary assessment, chiropractic and medical opinions and/or any other knowledge, information or data which you possess or have power to deliver, and for so doing kindly allow this to be your complete and sufficient authority.

_____

In consideration for your release of the information to my doctor, I hereby waive any patient privilege I may have regarding secrecy of chiropractic and medical information and I do release and discharge you and your assigns and/or successors of and from all claims for any damages resulting from the release of such information.

Date: _____

Signature: _____
Patient (or parent/guardian)

Witness: _____
Signature

Witness: _____
Name

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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, Corticosteroids, Cortisone Sulfonamides, Sulfonylureas, Thiazide Diuretics (water pills), Tetracyclines, Tricyclic Antidepressants, High dose Vitamin A (ie. Accutane), Immunosuppressant drugs

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.

_____	_____	_____
Date Signed	Patient Name	Patient Signature

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