# Balanced Health and Sports Therapy Chiro • Physio • Massage

### PHYSIOTHERAPY INTAKE FORM

Personal Information:			
Personal Information:		Da	ate:
		Last Name:	
Address:			
City/Province: Telephone: Home:	Post	al Code:	
l elephone: Home:	Cell:		_Work:
E-mail:	Alberta Health C	are Number:_	
Date of Birth (DD/MM/YYYY):		Age:	Sex:
Occupation:			
Please check what type of reminder you	ou would prefer:	_	
Email Reminder: Phone Call:	」 Text:		
Emergency Contact Information: Nam	e:	Pnone:	
How did you hear about the Balanced	Health and Sports Ther	apy?	<del></del>
Health Information:			
Why have you come for physiotherapy	2		
Are you receiving other treatments:			
		ot condition:	
If Yes With whom: Date of last treatment:	FUI WI	iai condition	Mharai
List surgaries and dates.	Date of last x-ray	v	vnere.
List surgeries and dates:			
Name of medical doctor:			
List current medications and dosage: _			
Do you smoke: ☐Yes ☐ No If Yes	How long: F	low many per	dav.
If female are you pregnant: Yes			
In your family is there a history of card	ovascular problems i.e.	. пеап апаск,	stroke; nigh blood
pressure or diabetes: Yes No			
What, if any, fractures or dislocations h	lave you had and when	÷	
List any motor vehicle accidents you h	ave been in and when t	hey occurred:	
List arry motor verticle accidents you in	ave been in and when t	ney occurred.	•
Any allergies to tape: ☐ Yes ☐ No	Do you have sensitive s		□No
Is there anything else about your healt			
.o more any mmig olee about your mount			
Can your medical doctor be contacted	with treatment updates	: □Yes □ N	lo
,			
PLEASE READ THOU	JROUGHLY AND SIG	ON WHERE	INDICATED BELOW
Please note our cancellation policy	: If less than 24 hour	rs' notice is (	given to cancel your appointment.
your account will be charged the full			giron to ouncer your appearances
, can account iiii ac ciiai gca iiic iai	· price or and appearing		
I UNDERSTAND THAT I WILL B	E CHARGED THE	FULL APPOI	INTMENT FEE ON ALL MISSED
APPOINTMENTS OR CANCELLATION			
SIGNATURE of Patient (or parent/gu	ardian)		DATE
·	•		

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











## **Balanced Health and Sports Therapy**

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#### **Informed Consent for Physiotherapy Treatment**

I acknowledge that I have been informed about the nature of physiotherapy treatment, including assessment, manual therapy, exercise prescription, and other therapeutic modalities. I understand the potential risks, benefits, and alternatives. I understand that I may decline or withdraw consent at any time without affecting my access to care.

#### Potential Risks of Physiotherapy Treatment

While physiotherapy is generally safe, I understand that there are potential risks associated with treatment, which may include but are not limited to:

- Temporary worsening of symptoms (e.g., increased pain or stiffness)
- Redness, skin irritation, or burns from modalities such as heat, ice, or electrical stimulation
- Sprains, strains, or soreness from the rapeutic exercises or manual therapy
- Headaches following manual therapy or postural adjustments
- Bruising from soft tissue techniques
- Damage to dental work from techniques involving pressure near the jaw or face

I acknowledge these potential risks and consent to proceed with physiotherapy treatment as

recommended by my	/ provider.	
	ual physiotherapy assessments ar that limitations may exist in virtual	nd treatments are an alternative to in-person assessments, and I consent to proceeding with
I consent to being co	ct (Phone/Email/Text) Intacted by Balanced Health and Sers, scheduling, and relevant health	ports Therapy via phone, email, or text for ninformation.
Acknowledgment a	nd Signature	
	understand the above information via phone, email, or text.	n, and I consent to physiotherapy treatment
Date Signed	Patient Name	Patient Signature (or Parent/Guardian)













## **Balanced Health and Sports Therapy**

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#### **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.

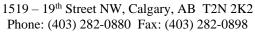
I understand and am informed that in the practice of acupuncture there are some risks to treatment, including but not limited to minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

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 Patient Signature (or parent/guardian)













# **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 SUMMUS® Medical Laser 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?		N	
3. Do you have a family history of cancer?		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?		N	
8. Do you have Heart or Kidney disease?	Y	N	
9. Are you taking any of the following medications (please circle):		N	
Antihistamine, Coal Tar and derivatives, Antifungals,			
Contraceptives (birth control), Phenothiazines, Psoralens, Cor	ticostero	ids, Cortis	one
Sulfonamides, Sulfonylureas, Thiazide Diuretics (water pills),	Tetracy	clines, Tri	cyclic
Antidepressants, High dose Vitamin A (ie. Accutane), Immun	osuppres	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.

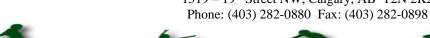
Pain relief from laser therapy may be dramatic and substantial, lasting for hours, days or weeks; however, your specific results may vary. Adverse effects from laser therapy may occur from multiple sources, in most cases involving a hypersensitivity to light, preexisting medical condition, thermal effects, 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.

outment by my emileran.			
Date Signed	Patient Name	Patient Signature	
	1519 – 19 <sup>th</sup> Street NW Cal	gary AR T2N 2K2	





# Balanced Health and Sports Therapy Chiro • Physio • Massage

Chiropractic and Physiotherapy Authorization to obtain medical records.

To: (record h	nolder – completed by office)	
BALANCED any and all limitation all progress not and medical	HEALTH AND SPORTS THERAP information they may so require in plain film radiographs including es, nurses notes, reports on diagno opinions and/or any other knowledges.	onditionally authorize you to release to or anyone they shall in writing designate relation to my health, including, but without x-ray films, radiology reports, clinical and stic test, secondary assessment, chiropractic ge, information or data which you possess of allow this to be your complete and sufficient
privilege I m release and	nay have regarding secrecy of chi	ion to my doctor, I hereby waive any patient ropractic and medical information and I do I/or successors of and from all claims for any mation.
Date:		
Signature:	Patient (or parent/guardian)	
Witness:	Signature	<u></u>
Witness:	Name	









