

Physiotherapy Registration, Consent & History form

Patient's Name: _____

PURPOSE OF CONSULTING WITH OFFICE (PLEASE CHECK ONE)

- I am interested only in help with my current condition(s), i.e. relief
- I am interested in help with my current condition(s) and learning how to correct and prevent it in the future, i.e. corrective care.
- I have no current problem, but I am interested in achieving the optimum level of function possible through preventive care. i.e. comprehensive care.

PATIENT CONDITION

Current symptom(s): _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain Sharp Dull Numbness Aching Shooting Burning
Tingling Throbbing Stiffness Swelling Other _____

How often do you have this pain? _____

Is it constant or does it come & go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities / Movements that are painful to perform Sitting Standing Walking Bending Lying Down

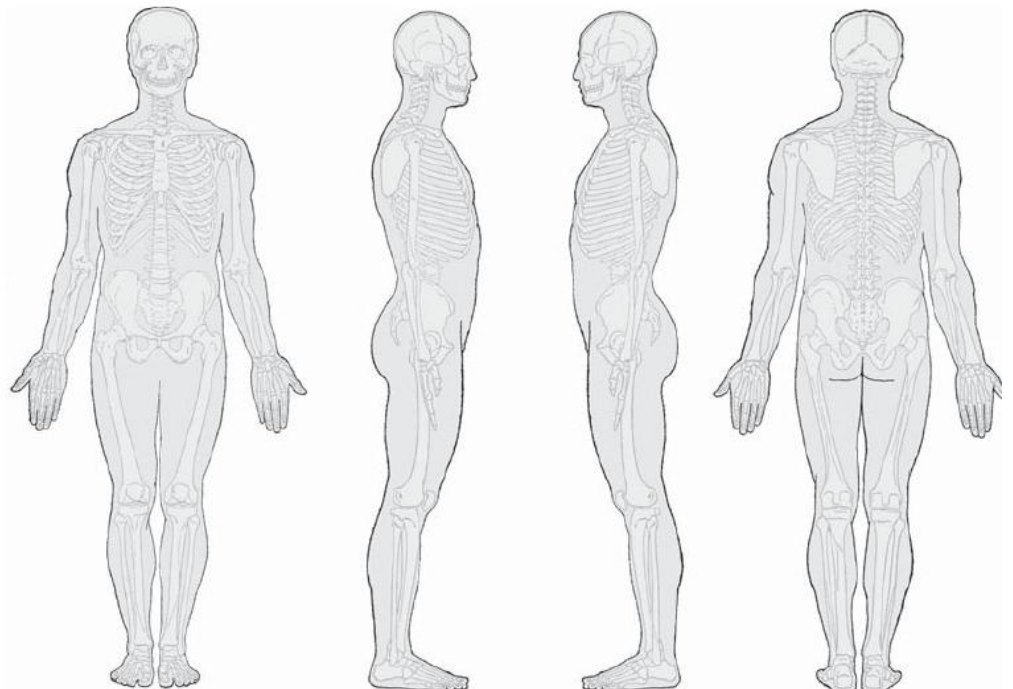
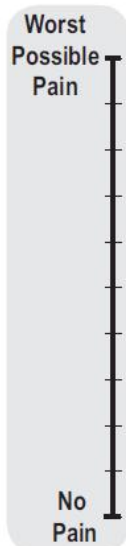
What treatments have you already received for your condition? Medical Phys Thp None Other

Name & address of other doctor(s) who have treated you for your condition _____

What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:



FILL OUT THE APPROPRIATE SECTION IF IT APPLIES:

A. WORKERS' COMPENSATION INSURANCE INFORMATION (if a work-related injury)

Name of Employer at time of injury _____ Date of Injury _____
Worker's Comp Insurance _____ Insurance Phone # _____
What part of your body was injured? _____ Claim Number or SS# _____
Have you had physical therapy for this condition? YES NO If yes, how many visits? _____

B. AUTO INSURANCE (if an auto injury)

Insurance Company _____ Insurance Phone _____
Insured's Name _____ Date of Accident _____
Adjustor's Name _____ Claim Number _____
Amount of Medical Pay Coverage (Please check your policy for this information) _____

Informed Consent to Assessment and Treatment

I hereby request and consent to the performance of physical assessment/ treatment procedures on me by the Physiotherapist identified below. My consent is voluntary and I intend this consent form to cover the entire course of assessment/ treatment for my present condition, commencing on the date indicated below.

I understand that I may ask questions at any time regarding:

- What the assessment/ treatment is
- Who will be performing the assessment/ treatment
- The reasons why I should have the assessment/ treatment
- The alternatives to having the assessment/ treatment
- What might happen if I do not have the assessment/ treatment
- What potential risks and/ or side effects exist for the proposed assessment/ treatment

I understand that this consent may be withdrawn, in writing, at any time, except for actions already taken.

Consent to Assessment, Treatment and Disclose Personal Health Information:

I hereby grant permission for Mississauga Wellness, PT to correspond with my physician(s) to obtain and exchange information relevant to my treatment. I realize that any information so obtained will be held in strict confidence.

Patient Name	Signature	Date
Physiotherapist Name		