CHARLTON PHYSIO AND WELLNESS

230 James Street South, 3rd floor,
Hamilton, ON L8P 3B3
Phone: (905) 528-5271
Email: info@charltonphysiotherapy.com

# INFORMED CONSENT

I hereby request and consent to the performance of treatment procedures by the Physiotherapist.
I understand that my treatment may consist of manual therapy techniques, therapeutic exercises including stretching and strengthening, use of weights and resistances, cardiovascular ex, as well as application of traction and electro therapeutic modalities which include IFC, US, Heat/Cold Therapy.
Before any of the procedures are performed my practitioner discussed my treatment options and only proceeds if my consent is given.
My practitioner has informed me of rare possibility of risks following the procedures, which include but are not limited to short term aggravation of symptoms, sprain/strain, stroke and chances of skin irritation or burns with the use of the therapeutic modalities.
I do not expect the therapist to be able to anticipate and explain all the possible risks and complications.
I wish to rely on the therapist to exercise judgement during the course of treatment, which they feel at the time, based on the facts that are known and are in my best interest.
I understand that the results are not guaranteed.
I authorize the practitioner to send/receive any information regarding my condition to/from other health practitioners, insurance companies or lawyers involved in my case.
I have read the above consent form and have had the opportunity to ask questions about its content.
By signing below, I agree to the above-mentioned procedures. I intend this consent form to apply to all my present and future physiotherapy care.
I also consent to the involvement of support person in my care assigned by the Physiotherapist.

N.B: Female Patients: I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant and that it is my responsibility to let the practitioner know if I am pregnant.

**READ BEFORE SIGNING:** Date: _____

Patient's Name: _____

Patient's Signature: _____

Physiotherapist's Name: _____

Physiotherapist's Signature: _____

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# Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Date of Birth (MM/DD/YYYY): _____

Address:

_____

Phone#: (Cell) _____ (Home) _____ (Work) _____

Email: _____ Occupation: _____

**Please indicate conditions you are experiencing or have experienced:**

**Cardiovascular**
- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ Chronic Congestive Heart Failure
- ○ Heart Attack
- ○ Phlebitis/Varicose Veins
- ○ Stroke /CVA
- ○ Pacemaker or similar device
- ○ Heart Disease

Is there a family history of any of the above? ◯ Yes ◯ No

**Respiratory**
- ○ Chronic Cough
- ○ Shortness of Breath
- ○ Bronchitis
- ○ Asthma
- ○ Emphysema

Is there a family history of any of the above? ◯ Yes ◯ No

**Infections**
- ○ Hepatitis
- ○ Skin Conditions
- ○ TB
- ○ HIV
- ○ Herpes

**Head/Neck**
- ○ History of Headaches
- ○ History of Migraines
- ○ Vision Problems
- ○ Vision Loss
- ○ Ear Problems
- ○ Hearing Loss

**Women**
- ○ Pregnant, due: _____
- ○ Gynecological Conditions, What?

_____

Overall, how is your general health?

_____

Primary Care Physician:

_____

Address: _____

_____

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**Other Conditions**

- Loss of sensation, Where? _____
- Diabetes, Onset: _____
- Allergies /Hypersensitivity to what? _____
- Epilepsy
- Cancer, Where? _____
- Arthritis _____

Is there a family history of arthritis? ◯ Yes ◯ No

Current Medications: _____

Condition it treats: _____

Are you currently receiving treatment from another health care professional?

Yes No

If Yes, for what? _____

Surgery Date: _____

Nature:_____

Injury - Date _____

Nature :_____

Do you have any other medical conditions? (e.g., digestive condition, Hemophilia, Osteoporosis, mental illness). ◯ Yes ◯ No

What? _____

Do you have any internal pins, wires, artificial joints or special equipment?

◯ Yes ◯ No

What? _____

Where? _____

What is the reason you are seeking Chiropractic Treatment/Physiotherapy?

_____

Please include the location of any tissue or joint discomfort. _____

_____