Leduc Wellness Centre Physical Therapy

CONFIDENTIAL PATIENT HEALTH RECORD

Name: _____

Address: _____

City/Province: _____ Postal Code: ___ ___ ___ - ___ ___ ___

Telephone: Residence: _____ Cell: _____

Email (appointment reminders and/or receipts): _____

Occupation: _____ Business Phone: _____

Date of Birth: _____/_____/_____ Age: _____
mm dd yr

Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Is this a Worker's Compensation Case? ☐ No ☐ Yes - Date of Accident? _____

Is this a Motor Vehicle Accident Case? ☐ No ☐ Yes - Date of Accident? _____

Date of Surgery: _____/_____/_____
mm dd yr

How did you hear about Leduc Wellness Centre? _____

MEDICAL HISTORY QUESTIONNAIRE

1. Please SELECT any of the following conditions that you have or have had in the past:

- ☐ Arthritis
- ☐ Broken Bones/Fractures
- ☐ Osteoporosis
- ☐ Circulation/Vascular Problems
- ☐ Heart Problems/Pacemaker
- ☐ High Blood Pressure
- ☐ Lung Problems
- ☐ Stroke
- ☐ Diabetes
- ☐ Low blood sugar/hypoglycemia
- ☐ Multiple Sclerosis
- ☐ Head injury
- ☐ Digestive Concerns
- ☐ Parkinson's Disease
- ☐ Seizure/Epilepsy
- ☐ Developmental/Growth Disorder
- ☐ Thyroid Problems
- ☐ Cancer (Type): _____
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ HIV+
- ☐ Other infectious diseases
- ☐ Skin diseases
- ☐ Depression
- ☐ Glaucoma
- ☐ Other: _____

2. Please list all past surgeries and the month/year they were performed:

_____

_____

_____

3. Please list all of the medication you are currently taking. If you do not remember the name, list what you take them for:

_____

_____

_____

4. Are you currently pregnant? ☐ YES ☐ NO

5. Has a doctor ever advised you not to exercise? ☐ YES ☐ NO

6. May we correspond with your physician(s) regarding your care? ☐ YES ☐ NO

7. Should your health benefit company contact us to confirm treatment dates may we give them that information? ☐ YES ☐ NO Please Initial: _____

Client Signature: _____ Date: _____

By my signature, I hereby authorize my child or dependant to have Physical Therapy treatments administered.

Signature of parent/guardian: _____ Date: _____

INFORMED CONSENT TO PHYSICAL THERAPY

PLEASE TAKE A MOMENT TO CAREFULLY READ THE FOLLOWING AND SIGN WHERE INDICATED

The Physical Therapist has provided me with understandable information on the following where applicable:

- My diagnosis, as currently known.
- The Physical Therapy treatment(s) being suggested.
- Significant risks, benefits, and alternatives to this treatment.
- The potential risks of foregoing the suggested care.

I have informed the treating therapist of all existing medical conditions, injuries past and present, and other physical limitations, including suspected pregnancy. I will notify the therapist of any changes or additions to this information as they arise.

I understand that I am responsible for communicating my response to the treatment to the best of my ability and reporting any changes in symptoms that may arise.

I understand that I am responsible for payment for all services rendered.

Should I have to cancel the appointment for any reason, I agree to give the therapist 24 hours' notice or I will be billed 50% of the cost of the appointment missed.

DO <u>NOT</u> SIGN THIS FORM UNTIL YOU MEET WITH THE PHYSICAL THERAPIST

I hereby acknowledge that I have discussed with the Physical Therapist the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to Physical Therapy treatment as proposed to me.

_____

Name (Please Print)

_____ **Date: _____, 20____.**

Signature of patient (or legal guardian)

_____ **Date: _____, 20____.**

Signature of Physical Therapist