

- PATIENT INFORMATION -
(Please Print Clearly)

In order to render treatment of a high standard, it is necessary to have the following information which will be handled confidentially.

Title: Mr. Mrs. Miss Dr

Surname: _____ Given Name: _____

Date of birth: / / Occupation: _____

Address - Private: _____

Phone # - Home: _____

- Mobile: _____

Email: _____

Where did you hear about PhysioFlex?

- Flyer/Brochure
- School
- Club/Sport
- Internet
- Drive by

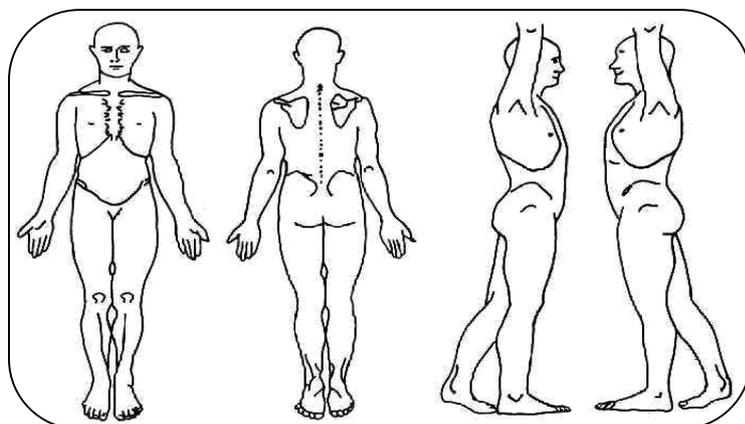
- Social Media: _____
- Friend: _____
- Family: _____
- Doctor: _____
- Other _____

-CONFIDENTIAL HISTORY-
(Please Print Clearly)

What is your major complaint?

How long have you had this problem?

Please Indicate on the diagram where you feel pain



Informed Consent

Physiotherapy involves the use of many different types of physical evaluation and treatments. At PhysioFlex, we use a variety of procedures and modalities to help improve your function. As with all forms of medical treatment, there are benefits and risks involved.

Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure such as massage, joint adjustment, traction and acupuncture to name a few. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury and aggravate a previous condition(s); electro-physical agents or tape may cause skin reactions; acupuncture can result in local swelling, bruising, skin infections or a collapse of a lung; and skin may react to massage oil or creams.

You have the right to ask your physiotherapist what type of treatment is planned based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before or during your treatment session.

Client Name: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____