

ATHLETIC THERAPY

<p>CONSENT FOR EXAMINATION, TREATMENT AND RELEASE OF PATIENT INFORMATION</p>

I, the undersigned, do hereby consent to examination/treatment at Reactive Sport Therapy, which may include modalities being electrical, ultrasound, or manual therapy as well as flexibility and strength training exercises.

I also authorize Reactive Sport Therapy to release medical information to Physicians, I.C.B.C., Lawyers and/or Insurance Companies that are directly involved in my care.

I further authorize ReActive Sport Therapy to obtain medical records regarding my diagnosed injury.

Expectations:

- 1. If I am not able to attend a scheduled appointment, **24 hour cancellation notice** is required. I understand if I fail to provide sufficient notice I will be responsible for payment for missed appointment.*
- 2. I will be provided with a Home Program with stretching and strengthening exercises and I am expected to complete the program, as recommended by ReActive Sport Therapy.*

I understand and agree to the above.

Dated this _____ day of _____ (month) _____ (year)

Signature (Please Print)

Signature

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MEDICAL HISTORY/LIABILITY: INFORMED CONSENT FORM

Past Medical History

- ___ High Blood Pressure
- ___ Low Blood Pressure
- ___ Heart Disease (Which one?)
- ___ Heart murmur
- ___ Pacemaker
- ___ Other heart problems
- ___ Lung Disease (Which one?)
- ___ Diabetes (Type 1 or 2)
- ___ Epilepsy
- ___ Neurological Disorder
- ___ Syncope (dizzy spells)
- ___ Arthritis (What kind?)
- ___ Allergies/Medications
- ___ Other Medical Conditions

Present Signs/Symptoms

- ___ Heart palpitations
- ___ Shortness of breath
- ___ Chest Pains
- ___ Extremity or Abdominal Pain
- ___ Coughing upon exertion (P)
- ___ Coughing up blood
- ___ Back pain (upper/mid/lower)
- ___ Stiff/painful/swollen joints
- ___ Drop Attacks
- ___ Muscle,tendon,ligament,bone
- ___ Paresthesia/ Loss of function
- ___ Major Surgery
- ___ Other Signs or Symptoms

Details:

INFORMED CONSENT

1. The medical history questions are answered to the best of my knowledge. I understand and I am aware that electrical and ultrasound equipment as well as strength and flexibility exercises, including the use of the equipment, is a potentially harmful activity. I also understand that I am voluntarily participating in these activities and using the equipment and modalities with all the knowledge of dangers involved. I hereby agree to expressly assume and accept any and all risks of harmful activities (Please Initial) _____.
2. I hereby waive any and all claims that I may have or may in the future have against Reactive Sport Therapy and its partners, and release Reactive Sport Therapy and its partner from any and all liability for any loss, damage, injury, or expense that I may suffer. (Please Initial) _____

I hereby affirm that I have read and fully understand the above.

Signature (Please Print)

Signature

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CLIENT INTAKE FORM

NAME: _____ **DATE** _____
BIRTHDATE: _____ **GENDER** M / F ____
ADDRESS: _____
CITY _____ **POSTAL CODE** _____
PHONE#: (H) _____ (W) _____ (C) _____
EMAIL ADDRESS: _____
OCCUPATION _____
SPORT/ACTIVITY _____

DOCTOR: _____ **PHONE #** _____
DATE OF INJURY _____
MOI: How did injury happen? _____

INJURY: Soft Tissue _____
Bone/Joint _____
XRAYs/MRI/CTScans: _____
ALLERGIES: _____
MEDICATIONS: (OTC, prescription, etc) _____

REFERRAL: Name (s) and Number (s)
