Patient Information Form

Balance Health Physiotherapy
379 Queen Street
Charlottetown, PEI, C1A4C9
(902) 370-3322

Who were you referred by?________________________________

General Information

First Name_______________ Last Name________________ DOB (d/m/y)____/____/____

☐ Male ☐ Female Age________

Phone_____________________ Email Address:____________________________________

Mailing Address:____

Occupation________________________

Emergency Contact _________________ Relationship__________ Phone______________

Family Physician_________________________________

Are you currently under a Physician's care, including restrictions, for any reason? ☐ Y ☐ N

Are you currently seeing any other health care professionals? ☐ Y ☐ N

Please specify____

Medications

List all current medications

Medication:

1. ____
2. ____
3. ____
4. ____

Hospitalization / Operations (*in the last 5 years*)

1. ______________________________ Date: ________________________
2. ______________________________ Date: ________________________

Past Medical History

Please list any medical conditions:

1. ____
2. ____
3. ____
4. ____

Balance Health Physiotherapy Informed Consent Form

Please read the following statements and sign below.

- I must inform this office of any other practitioner (other than physicians) that I am currently seeing.
- I must inform my physiotherapist of any contagious or infectious condition that I might have.
- I understand that I need to express all of my health concerns (both current and past) to my physiotherapist.
- I understand and agree that my health information will be maintained by Balance Health Physiotherapy in an electronic form and may be electronically transmitted to third parties as required in the course of my treatment.
- I consent to an examination and treatment performed by a licensed physiotherapist. The results will the assist the physiotherapist in determining the appropriate physical treatment to meet my specific needs and goals. I understand that the treating physiotherapist will discuss the treatment plan, including potential risks and benefits of specific treatments, and the frequency of treatment recommended.
- I understand that discomfort may occur following treatment. The therapist will contact my physician should the presence of symptoms represent any potential risks. I understand that it is my responsibility to contact a therapist in the clinic should I experience any unusual symptoms.
- I understand that if at any time I am not comfortable with, and/or do not understand the purpose of any treatment procedure I will ask the physiotherapist for further explanation/information. I understand that I may stop the assessment or treatment procedure at any time, during or after a session.

I have read, understood, and had opportunity to discuss the Patient Information form, the Privacy Policy and Information Release Authorization form, the clinic's fee structure, and the Sensitive Practice Policy.

My signature below indicates my understanding of all of the above information.

Patient Signature ____ Date:____________________

Therapist Signature ____Date: ____________________

If under 16 years of age, the following section of the consent form must be completed by a parent or guardian before treatment can be initiated.

I have read and fully understand all of the above information and give my permission to have

_____________________________________ Assessed and/or treated at Balance Health Physiotherapy.

Parent Signature ____Date:____________________

Therapist Signature ____Date: ____________________