Biodynamics TORONTO

542 Mount Pleasant Road, Suite 201
|p: (416) 917-9090 |e: biodynamicstoronto@gmail.com
|w: Biodynamicstoronto.com

PHYSIOTHERAPY INFORMED CONSENT

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

I, undersigned, do hereby give my voluntary consent for the administration of Physiotherapy deemed appropriate by my treating Physiotherapist. I understand that Physiotherapy treatments may include an individualized exercise prescription and various forms of manual therapy techniques such as mobilization, manipulation, soft tissue release and stretches. Treatments may also include modalities such as heat, ice, acupuncture/dry needling, therapeutic taping, ultrasound, laser, TENS, interferential current, shock wave and electric muscular stimulation.

I understand that the primary goals of Physiotherapy treatments are to help reduce my pain and improve my mobility, strength, endurance, function and quality of life. I understand that there are very small possibilities of risks or complications that may result from the above listed treatments. I do not expect the Physiotherapist to anticipate all the possible risks and complications. I wish to rely on the Physiotherapist to exercise proper judgment during the course of treatment to make decisions based upon my best interest.

I understand that a confidential record will be kept of the health services provided to me. This record will be kept confidential but if required, for insurance or health reasons I understand that I may look at my medical records at any time and can request a copy of my file with a fee of $0.10 per page with at least 72 hours' notice. Additional charges may apply if your practitioner is requested to write letters for insurance or medical practitioner purposes.

I understand that I need to give 24 hours' notice for any cancellation. If I give less than 24 hours' notice, then I agree to pay the sessions full fee. Exceptions may apply at the practitioner's discretion. If you are late for an appointment, please be advised that the appointment will not continue past the previously scheduled end time.

I have had the opportunity to discuss with the Physiotherapist, the nature and purpose of these treatments. I understand that the results are not guaranteed. I do not expect the Physiotherapist to be able to anticipate and explain all risks and complications.

I have read and understand the above statement, accept the risk and hereby consent to treatment. I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent at any time.

Patient or Legal Guardian Name ______________________________

Signature of Patient or Guardian ____________________ **Date**: __________

Witness ______________________________ **Date**: __________

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PHYSIOTHERAPY PATIENT INTAKE FORM

This is a confidential record of your personal information and your medical history and will be kept in this office. Information contained in it will not be released to any person unless you authorize us to do so.

Personal information

Name____

Phone ______________________ E-mail ______________________

Address____

City____________________ Province ______________ Postal Code ____________

Date of Birth______________________ ☐Male ☐Female

Occupation ______________________

Emergency contact ____

Phone ______________________ Relation ______________________

Medical doctor ______________________ Phone ______________________

How did you hear about us? ☐ Website ☐ Social media ☐ Friends ☐ Family☐ Newspaper ☐ Other ______________________________

PRESCRIPTION DRUGS

List all prescription drugs that you are currently taking. Indicate present dose and how long you have been on each medication.

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____

____

List all prescription drugs you have taken in the past for longer than six months. Indicate how long you were on each medication.

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SURGERY

List any major surgery you have had.

#1 year__________ nature______________________________

#2 year__________ nature______________________________

#3 year__________ nature______________________________

Do you have any internal pins or artificial device? ☐Y ☐N Nature______________________

MEDICAL HISTORY

In the lists below, check all major illnesses that you have experienced.

Childhood disease

- ☐ Measles
- ☐ German measles
- ☐ Chicken pox
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Whooping cough
- ☐ Scarlet fever
- ☐ Polio
- ☐ Reye's syndrome

Infectious disease

- ☐ Worms/Parasites
- ☐ Cholera
- ☐ Malaria
- ☐ Typhoid
- ☐ Tuberculosis
- ☐ Syphilis
- ☐ HIV

Ears Nose Throat system

- ☐ Environmental allergies
- ☐ Hay fever
- ☐ Ear infections (repetitive)
- ☐ Tonsillitis
- ☐ Strep throat
- ☐ Chronic sinusitis
- ☐ Eye Problems

Respiratory system

- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Pleurisy
- ☐ Asthma
- ☐ Emphysema

Cardiovascular system

- ☐ Heart problems
- ☐ Heart attack
- ☐ Angina
- ☐ Congestive heart failure
- ☐ Stroke/CVA
- ☐ Aorta aneurysm
- ☐ Varicose veins
- ☐ Phlebitis/Thrombosis
- ☐ Raynaud's disease
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Pacemaker/Artificial valve

Gastrointestinal tract

- ☐ Digestive allergies
- ☐ Food poisoning
- ☐ Esophageal varicose
- ☐ Hiatal hernia
- ☐ Stomach/Duodenum ulcers
- ☐ Crohn's Disease
- ☐ Irritable bowel syndrome
- ☐ Candida yeast syndrome
- ☐ Appendicitis
- ☐ Pancreatic disease
- ☐ Liver disease
- ☐ Jaundice
- ☐ Wilson's disease
- ☐ Hepatitis
- ☐ Gall bladder disease
- ☐ Spleen disease
- ☐ Colitis
- ☐ Diverticulitis
- ☐ Hemorrhoids
- ☐ Colorectal disease

Genito-urinary system

- ☐ Urinary tract infections
- ☐ Bladder problems
- ☐ Kidney stones
- ☐ Kidney infections

Female

- ☐ Uterine fibroids
- ☐ Endometriosis
- ☐ Ovarian cysts
- ☐ Vaginitis (recurrent)
- ☐ Human Papillomavirus
- ☐ Fibrocystic breast disease
- ☐ Infertility

Male

- ☐ Prostate problem
- ☐ Impotence
- ☐ Scrotal hernia
- ☐ Infertility/Low sperm count

Pelvic inflammatory diseases

- ☐ Chlamydia/Gonorrhea
- ☐ Genital warts
- ☐ Genital herpes
- ☐ Herpes (cold sores)

Endocrine disease

- ☐ Diabetes
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Cushing's Disease
- ☐ Addison's Disease

Musculoskeletal system

- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ Rheumatism/Arthritis
- ☐ Fibromyalgia
- ☐ Osteoporosis/Osteopenia
- ☐ Myasthenia gravis
- ☐ Rickets syndrome
- ☐ Herniated disc
- ☐ Bursitis

Neuro

- ☐ Concussion
- ☐ Epilepsy
- ☐ Meningitis/Encephalitis
- ☐ Multiple Sclerosis
- ☐ Sciatica
- ☐ Thoracic outlet syndrome

Metabolic diseases

- ☐ Hypoglycemia
- ☐ Anemia
- ☐ Platelet disorder
- ☐ Gout
- ☐ Lupus
- ☐ Malnutrition
- ☐ Cancer, specify type:

Skin

- ☐ Acne
- ☐ Boils
- ☐ Impetigo
- ☐ Eczema
- ☐ Shingles
- ☐ Psoriasis
- ☐ Warts
- ☐ Hives
- ☐ Ulcers
- ☐ Skin cancer

Psychological

- ☐ Schizophrenia
- ☐ Bipolar disease
- ☐ Clinical depression
- ☐ Suicidal tendencies
- ☐ Eating disorder
- ☐ Emotional problems
- ☐ Other psychological problem

Please check the box if you are currently experiencing the following symptoms or write "P" if you have experienced them in the past.

General

- ☐ Poor/Change in appetite
- ☐ Nervousness
- ☐ Weight gain
- ☐ Weight loss
- ☐ Poor sleep
- ☐ Chronic fatigue
- ☐ Chills and fevers
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Cravings
- ☐ Strong thirst

Ears Nose Throat

- ☐ Migraine/Headaches
- ☐ Facial pain/tics
- ☐ Ear aches
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Nasal obstruction
- ☐ Post nasal drip
- ☐ Nosebleeds
- ☐ Loss of taste/smell
- ☐ Sinus infection
- ☐ Enlarged glands
- ☐ Enlarged thyroid
- ☐ Sore throat

Eyes

- ☐ Eye pain
- ☐ Eye strain
- ☐ Blurry vision
- ☐ Impaired vision

Dental

- ☐ Jaw pain or clicks
- ☐ Mercury fillings
- ☐ Sores in mouth
- ☐ Grinding/Clenching teeth
- ☐ Extractions
- ☐ Orthodontia

Respiratory

- ☐ Difficulty breathing
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Coughing blood
- ☐ Throat phlegm
- ☐ Wheezing

Cardiovascular

- ☐ Palpitation
- ☐ Irregular heartbeat
- ☐ Fainting
- ☐ Chest pain
- ☐ Cold hands or feet
- ☐ Swelling of limbs
- ☐ Poor circulation

Gastrointestinal

- ☐ Bad breath
- ☐ Gas or burping
- ☐ Indigestion
- ☐ Constipation
- ☐ Diarrhea
- ☐ Incomplete bowel movements
- ☐ Abdominal pain or cramps
- ☐ Nausea
- ☐ Vomiting
- ☐ Chronic laxative use
- ☐ Rectal pain
- ☐ Blood in stool
- ☐ Constant hunger
- ☐ Colon trouble
- ☐ Bloating

Musculoskeletal system

- ☐ Neck pain
- ☐ Back pain
- ☐ Muscle pain
- ☐ Other pain
- ☐ Orthotics

Skin and Hair

- ☐ Rash
- ☐ Itching
- ☐ Loss of hair
- ☐ Thinning hair
- ☐ Dandruff
- ☐ Recent moles
- ☐ Dryness
- ☐ Allergic reaction
- ☐ Keloids
- ☐ Other skin problem(s)

Female

- ☐ Premenstrual syndrome
- ☐ Irregular periods
- ☐ Heavy flow
- ☐ Light flow
- ☐ Clots
- ☐ Pain/Cramps
- ☐ Sore breasts
- ☐ Vaginal discharge
- ☐ Lower back pain
- ☐ Menopause

Birth control Type ______________

Date of last Pap ________________

Age of first menses ____________

Pregnancy

- ☐ Currently pregnant
- ☐ Extra-uterine pregnancy
- ☐ Abortion
- ☐ Miscarriage
- ☐ Epidural
- ☐ Episiotomy
- ☐ C-section
- ☐ Pelvic floor rehabilitation
- ☐ Uterine prolapse
- ☐ Gestational diabetes
- ☐ Pre-eclampsia
- ☐ Other pregnancy related illness

Urinary system

- ☐ Frequent urination
- ☐ Urgency to urinate
- ☐ Pain on urination
- ☐ Wake up at night to urinate
- ☐ Incontinence
- ☐ Blood in urine

Neuro

- ☐ Numbness
- ☐ Muscle weakness
- ☐ Loss of balance
- ☐ Irritable
- ☐ Poor memory
- ☐ Anxiety
- ☐ Dizziness
- ☐ Lack of coordination
- ☐ Seizure
- ☐ Loss of sensation

HEALTH CONCERNS

- **What are your main health concerns in order of importance to you?**

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- **Visual Pain Rating Scale**

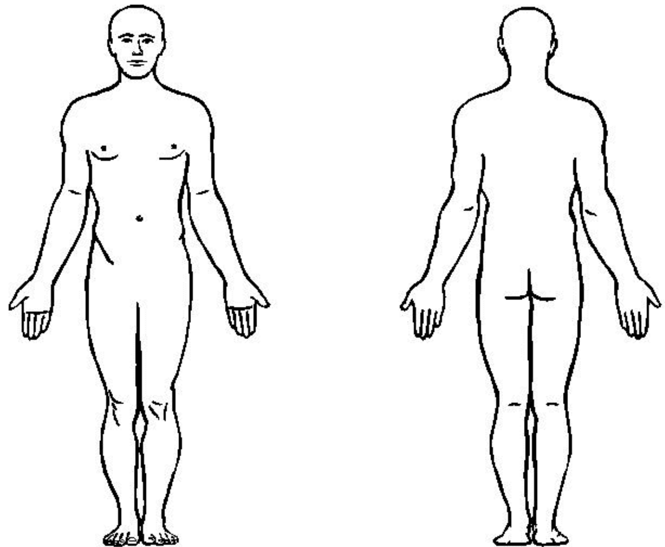
Make a mark along the line which you think represents your current level of pain.

No pain at all ____ **As bad as it could be**

- **Pain Diagram**

On the following diagrams, indicate all areas of:

¬ Pain : XXXX
¬ Stiffness : ////
¬ Numbness : 0000
¬ Other (specify) :



SIGNATURE

I attest that the information provided is true and accurate to the best of my knowledge.

Signature: ________________________________ Date: ________________________

Thank you for taking the time to fill out this questionnaire.

It will help greatly in our study of your present health concerns and in our understanding of your health goals.

Your responses will assist us in choosing the appropriate treatment that will bring about your return to optimal health.