307 Robinson St. Oakville, ON L6J 1G7
Tel: 289 805 2252 Fax: 289 805 2253
info@lakesidephysiomassage.com

Lakeside Physiotherapy Intake Form

Full Name:	
Address:	**Cell Phone**:
City: APT#	Home Phone:
Postal Code:	**Birth Date (DD/MM/YY):**
Occupation:	Email Address:
Employer:	**How did you find us?**
Emergency Contact:	Phone #:

Doctor: Phone:

Medications: Conditions being treated:

Injuries: Nature: Date:

Surgery: Nature: Date:

Other conditions (digestive, gynecological etc.):

Of special note (presence of pins, plates, wires, artificial joints, special equipment wheelchair/ walker

____

Are you here as a result of a motor vehicle accident? Yes No	
Name of Automobile Insurance Company:	
Insurance adjustor name:	Phone # Fax#
Claim/Policy#	Date of Accident:

Please SIGN & COMPLETE Authorization for LAKESIDE to Submit Claim on your behalf Name of Medical Insurance Co.	
Policy No.	Member ID
Coverage Amt:	Coverage %
Signature of Applicant:	

CANCELLATION POLICY:

Your time is reserved for you. Please provide a MINIMUM of 24 HOURS to Cancel or Reschedule your appointment. If you do not provide us with 24 hours you will be charged a missed appointment fee for the service to which you were schedules for.

Signature:_______________________________ Date:_____________________________

lakeside
Physiotherapy & Massage
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Physiotherapy Informed Consent Form

Please read the following statements carefully and sign below

I hereby request and consent to an examination and treatment performed by a licensed Physiotherapist. The results will assist the Physiotherapist in determining the appropriate physical treatment to meet my specific needs and goals. I understand that my treatment in this clinic may involve the use of:

- **Various physical & electrical modalities (heat, ice, ultrasound, TENS, IFC, Laser)**
- **Stretching or mobilization of joints and tissues**
- **Exercise programs aimed at mobility, strength and function**
- **Acupuncture**

I understand that discomfort may occur following treatment. I understand that it is my responsibility to contact my 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 must inform my Physiotherapist of any contagious or infectious conditions that I might have.

I understand that I may stop the assessment or treatment procedure at any time, during or after a session. I wish to rely on the Physiotherapist to exercise judgement during the course of the treatment and that results are not guaranteed.

I have read, understood, and had opportunity to ask questions regarding this consent form. I intend this consent to cover the entire course of treatment for my present and future conditions for which I seek treatment.

My signature below indicates my understanding of all the above information

Client Name: ____

Signature : ____

Date: ____