Truhealth & wellness
Achieve and maintain a higher personal best.

Date: ___________________

Health Assessment

About You

Name: ___________________________________ Gender: M / F Date of Birth: _____________________

Address: ____ City: ___________________

Province: ______________________________ Postal Code: _____________________

Email: ____

Phone Number (H): _________________________________ Phone (C): _______________________________

Pain, Injury and or Chronic Conditions

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Confidentiality: We are committed to protecting your privacy. The information requested is being collected for the sole purpose of developing, managing and directing your treatment plan. Only health professionals working on, or with, your assessment/treatment will view this information. Any additional questions or clarifications required will be addressed with you directly during your assessment and at no time will we divulge your name or any other information provided, to any third party without your explicit permission

Informed Consent

Your health information is confidential. We need this information so that we may better care for you. Your consent will help us determine if treatment in our office can help you. If we do not sincerely believe that your condition will respond satisfactory, we will not accept your case.

As a matter of ethics and law, there is an obligation, prior to examination and treatment to discuss any material risk to the patient in order to obtain informed consent. There are risks and possible risks associated with manual therapy techniques used by Physiotherapist. In particular, you should note, there are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy or ultrasound therapy offered by some Physiotherapist.

As part of the massage/physiotherapy and rehabilitative treatments, certain procedures and devices may be utilized such as the use of heat, ice, electrotherapy, ultrasound and or manual therapy including mobilization. Furthermore, as [art of the rehabilitation program, certain testing procedures, devices and equipment may be utilized such as weight machines, exercises, cardiovascular work and functional tasks.

I have had the opportunity to discuss with the Massage Therapist / Physiotherapist, the nature and purpose of the treatments. I understand the results are not guaranteed. I understand and consent that the Massage Therapist/physiotherapist may assign certain aspects of my care to their support personnel.

I further understand and I am informed that there are some risks to the treatments including, but not limited to; muscle strains, sprains, stroke, disc injuries, dizziness, nausea, heart attack and burns. The risk of injury or complications from physiotherapy are substantially lower than that associated with many medical or other treatments, medications and procedures given for the same symptoms. I have been made aware that appropriate tests will be performed to help identify if I may be susceptible risk or injury.

I have read and understand the above statement. I hereby consent to examination and/or treatment.

Patient Name: ________________________________ Patient Signature: _____________________________