McAllister Chiropractic and Massage

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 therapist.
- I consent to an examination and treatment performed by a licensed physiotherapist. The results will then 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 and electrical modalities
  - Acupuncture
  - Stretching or mobilization of joints and tissues
  - Exercise programs aimed at mobility, strength and function
- 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 understand that the Clinic will send an initial assessment and follow-up report(s) as appropriate to the licensed practitioner who referred me to the clinic for treatment.
- I have read, understood, and had opportunity to discuss the Client Information form.

My signature below indicates my understanding of all the above information

____ ____________________

Signature of Client Date

If under 16 years of age, the following must be completed by a parent/guardian prior to treatment:

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

____________________________________ assessed and/or treatment at this Clinic.

______________________ ______________________ ____________________

Printed name of parent/guardian Signature of parent/guardian Date

I consent to have communication via email? ☐ **Yes** ☐ **No**

Email	

SEP 2015