Laurie Wiens Physical Therapy and Acupuncture

Initial information Sheet

Name: _____ Date of Birth_____

Address:_____ Referred by:_____

City:_____ Family Dr.:_____

Postal Code:_____ Heath Num:_____

Phone: (H)_____ Date of Initial Visit:_____

(W)_____ Email:_____

(C)_____

Emergency contact:_____

Phone Number:_____

Is this related to WCB or SGI

_____Yes _____No

Off work due to this condition

_____Yes _____No

If yes, what is your claim number:

_____

Reason for Visit: _____

_____

_____

_____

_____

Laurie Wiens Physical Therapy and Acupuncture

1814 Lorne Avene

Saskatoon, SK

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name _____ Health Number:_____

Address: _____

I hereby consent to the release of information, records, x-ray films/reports to Laurie Wiens Physical Therapy and Acupuncture. I also consent to the release of information from Laurie Wiens Physical Therapy and Acupuncture to be shared with the following parties which may include: family doctor, medical specialists, care providers, employer, case workers and any other person I feel necessary to include as listed below:

Consent to obtain information	Consent to send information
From the following persons:	To the following persons:
_____	_____
_____	_____
_____	_____

_____Check if a written report is not needed.

CONSENT FOR EXAMINATION AND TREATMENT

I am about to be examined and treated by a licensed physical therapist. I agree that to be properly examined and treated I need to express my health concerns. I may need to west clothing that will allow my body to be examined. It will be necessary for the therapist to touch and move my body appropriately in order to evaluate and plan treatment. I may have a third party in the room at my request.

I understand that treatment may involve the use of various physical and electrical modalities and/or acupuncture, mobilization or manipulation of joints and soft tissues, exercises- flexibility and strengthening. I understand that there may be some soreness after treatment. It is my responsibility to inform my therapist if I experience any unusual symptoms following the assessment and treatment. The therapist will contact my physician should the presence of other signs or symptoms represent any potential risks.

I understand that there is a cost to prepare copies of information from my chart or for completion of various forms if requested. I understand that any cancellations should be made 24 hours in advance of my appointment where possible. My signature below indicates my consent to and understanding of the above information.

Signature: _____ Date: _____

Witness: _____ Date: _____