www.proactiveathletictherapy.com
613-276-8884
130 Lansdowne Ave., Unit 9,
Carleton Place ON K7C 2T7

Athletic Therapy Patient Health History

Name: _____ Date of Birth (Month/Day/Year) _____
Address: _____City: _____
Province: _____ Postal Code: _____
Home Telephone No: _____ Mobile No: _____
Work Telephone No: _____ Email: _____
Emergency Contact: _____ Telephone No: _____
Family Physician: _____
How did you hear about us?
Our Website _____
Referral _____
Our Sign _____

Please circle which applies to your health history and explain in detail if needed.

Allergies	Y	N	_____
Cardiac (Heart) Conditions	Y	N	_____
Pacemaker	Y	N	_____
Respiratory Conditions	Y	N	_____
Medications	Y	N	_____
Cancer	Y	N	_____
Diabetes	Y	N	_____
Metal Screws or Implants	Y	N	_____
Joint Replacement	Y	N	_____

I understand that it is my responsibility to inform the Athletic Therapist of any changes to my health history as soon as possible.

PAYMENT IS DUE WHEN SERVICE IS RENDERED.

Signature of patient: _____ Date: _____

Parent or Guardian must sign for patient under the age of sixteen (16).

PLEASE COMPLETE SECOND PAGE>

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CONSENT FORM

I _____ hereby give ProActive Athletic Therapy my consent to have my Healthcare Provider release/obtain reports and/or information from the following individuals with respect to my care.

Physician/Specialist _____ _____ Initials
Insurance Provider _____ _____ Initials

PAYMENT DETAILS

I understand that it is my responsibility to provide payment for the services received at ProActive Athletic Therapy on the day these services are rendered. It is my responsibility to submit my treatment invoices to my Insurance Provider, Employer, VAC or WCB/WSIB. ____Initials

NO SHOW/SHORT NOTICE CANCELLATION FEE

Your appointment time has been reserved specifically for you. If you book a treatment and then choose to not attend, you may be billed for the treatment. If your cancellation is less than 24 hours notice, you may also be charged for the treatment. ___Initials

TREATMENT INFORMATION

I hereby give verbal and written consent to ProActive Athletic Therapy for Athletic Therapy Assessment and Treatment. Athletic Therapy Treatment techniques include, but are not limited to manual techniques such as soft tissue release and joint mobilizations as well as a personalized home exercise program. ____Initials

Throughout your program if you have any questions or concerns about any recommended treatment, you must notify your Athletic Therapist immediately so they can explain the treatment rationale and/or modify your program for you. ___Initials

I understand that consent can be withdrawn at any time by verbally informing the Athletic Therapist and treatment will be stopped. ___Initials

_____ Date: _____
Signature (Parent or Guardian must sign for patient under the age of sixteen (16).

_____ Date: _____
Witness