HUMBOLDT
THERAPY CENTRE

521 7th Street
Box 2410 Humboldt, SK S0K 2A0
P: (306) 682-6610; F: (306) 682-6636; E: reception@humboldttherapycentre.ca

Client Registration

Name: _____

Mailing Address: _____
_____
_____

Home Phone #: _____ Work/Cell # _____

Gender: Male ☐ Female ☐

Email Address: _____

Date of Birth: _____

Injury Date: _____ 1st Appt. Date: _____

Area of Injury: _____

Referred by: _____

Saskatchewan Health Services Card #: _____

Family Physician: _____

WCB/SGI Claim #: _____

Adjuster/Case Service Representative: _____

Occupation: _____

Employer: _____

Work Phone #: _____
Fax #: _____

Next of Kin: _____

Phone #: _____

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CONSENT FOR PHYSICAL THERAPY TREATMENT

Physical therapy services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability. The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures including, but not limited to, mobilization, massage, exercises, spinal traction, and physical agents. Physical therapist's main goal is to aid the client in achieving their maximum potential within their capabilities and to accelerate recovery. All procedures will be thoroughly explained to you before they are performed.

Response to physical therapy intervention varies from person to person. Therefore, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Humboldt Therapy Center (HTC) does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in a temporary aggravation of existing symptoms and may cause pain or further injury. Other risks may include, but not limited to, temporary bruising, headaches, tenderness, and swelling.

Should you feel any discomfort, pain or have other unresolved concerns, it is your right to decline any part of your treatment at any time. It is your right to ask your physical therapist about the treatment they have planned and/or to discuss the potential risks and benefits involved in your treatment.

I agree that sessions and communications will not be recorded or shared without the permission of all parties involved.

I, _____, have read this consent form and fully understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I, or myself, my heirs and assigns, hereby release HTC from any claims, demands and causes of actions arising form my participation in these physical and exercise therapy treatments. **I am aware of and understand that a $25.00 fee will be charged to all clients (private, WCB, and SGI) for short notice cancellation (less than 24 hours notice) and a $50.00 fee will be charged for a missed ½ hour treatment appointment. There will be a 50% fee of total cost if a multi-hour appointment is missed such as functional testing or program development.**

_____ _____

(Signature of Client) (Date)

_____ _____

(Signature of Parent or Legal Guardian) (Signature of Witness)

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CONSENT TO RELEASE/OBTAIN INFORMATION

I, _____, herby authorize Humboldt Therapy Centre to:

- Release copies or give a verbal report of my assessment, treatment plan, interim progress report(s), discharge plan and follow-up reports as applicable, to all individuals or agencies listed below
  and/or
- Contact any of the individual(s)/organization(s) named for the purpose of obtaining information regarding my injury, impairment, disability, functional or vocational needs.
- Access PACS (Picture Archiving and Communications System) for the purpose of obtaining medical imaging.

_____ Physician

_____ Other individual(s) (WCB, SGI, GWL etc.)

_____ Chiropractor

_____ Rehabilitation Management Co./Case Worker

_____ Physiotherapist

_____ Employer/name of contact

I have read the above authorization(s) and indicate my consent by my signature. This authorization will be valid twelve (12) months from this date.

_____ Signature of Client

_____ Date

_____ Signature of Parent or Legal Guardian

_____ Signature of Witness

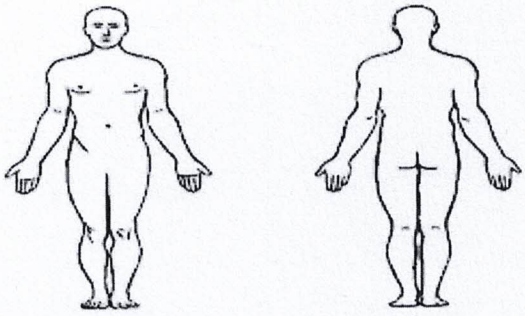
HUMBOLDT THERAPY CENTRE - INJURY INTAKE FORM

Name: _____

Date of Injury/How long pain has persisted: _____

How did this injury occur? _____

Fill in Diagram below:
OO dull pain
XX sharp pain
** numbness/tingling



Rate your pain 0-10 (0 being none, 10 being worst imaginable): Present_____ Worst_____ Best_____

What improves your pain? _____

What makes your pain worse? _____

What has your injury/pain held you back from doing (Work, hobbies, etc)?: _____
_____

Previous Medical History (Please check all that apply, past or present):

- ☐ Headaches
- ☐ Blood Pressure
- ☐ Depression
- ☐ Anxiety
- ☐ Anorexia/Bulimia
- ☐ Memory Loss/ Feeling foggy
- ☐ Dizziness/Vertigo
- ☐ Severe Nausea
- ☐ Hypersensitivity to Heat/Cold
- ☐ Poor Circulation
- ☐ Heart Disease
- ☐ Stroke
- ☐ Pacemaker
- ☐ DVT
- ☐ Respiratory Disease
- ☐ Pulmonary Embolism
- ☐ Epilepsy
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Incontinence
- ☐ HIV/AIDS/Hep C
- ☐ Currently Pregnant
- ☐ Miscarriage
- ☐ Cancer:_____
- ☐ Surgical Implants: _____
  _____
- ☐ Allergies:_____
  _____
  _____
- ☐ Past Surgeries:
  _____
  _____
  _____
  _____
- ☐ Other/Fractures:
  _____
  _____
  _____
  _____

LIST OF MEDICATIONS:

_____
_____
_____
_____
_____
_____