ZONE
SPORTS PHYSIOTHERAPY

Returning Client Information Update

Client Name (please print)_____ Date of Birth:___/_____/_____(dd/mm/yy)

Please **print** first and last name

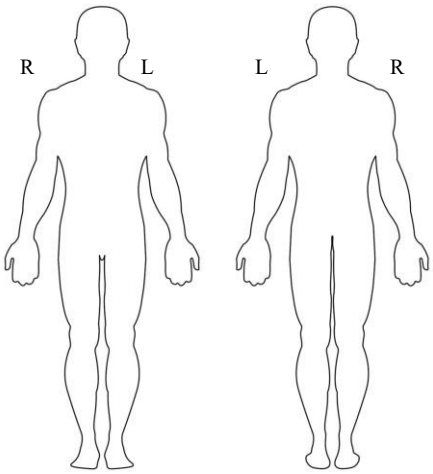
Date of Assessment:____/_____/_____(dd/mm/yy)

1. In the past 6 months, have you had any significant changes to your general health?
   - ☐ Yes - please describe: _____
   - _____
   - ☐ No
2. In the past 6 months, have you had any significant injuries (NOT including your injury visit today)
   - ☐ Yes - please describe: _____
   - _____
   - ☐ No

Please complete the following about your visit ***today***

Reason for Visit: ☐Sports Injury ☐Personal Injury ☐Surgery ☐ Work Injury ☐Auto Injury ☐Other: _____

Please indicate the area(s) of injury/discomfort



PAIN SCALE RATING

Please rank your pain with "0" being no pain and "10" being worst pain possible

At Rest

0 1 2 3 4 5 6 7 8 9 10

NO PAIN — WORST POSSIBLE PAIN

With Activity

0 1 2 3 4 5 6 7 8 9 10

NO PAIN — WORST POSSIBLE PAIN

Have you had any of the following diagnostic exams/tests for this injury

- ☐ Xray
- ☐ Ultrasound
- ☐MRI
- ☐CT Scan
- ☐Bone Scan
- ☐ EMG/Nerve Conduction

Have you received care from any of the following health care professionals for this injury

- ☐ Family Physician
- ☐ Orthopaedic Surgeon
- ☐Specialist _____
- ☐ Physiotherapist
- ☐ Chiropractor
- ☐Massage Therapist
- ☐ Acupuncture
- ☐ Other _____

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Consent Form

Client Name: _____ Date of Birth: ____/____/____
Please print first and last name dd mm yy

☐ Please check if the client is a minor (under the age of 18)

Consent Designate Name : (please print) _____
Relation to client: ☐ Parent ☐ Family Member ☐ Guardian

1) Assessment and Treatment:

I hereby consent to participate in my rehabilitation program at ZONE Sports Physiotherapy. This will include assessment and treatment with physiotherapy. If I have any questions or concerns regarding this treatment, I will ask the attending therapist for clarification. If I choose not to participate in the program or a portion of treatment, I will inform my physiotherapist immediately. I understand that for the duration of my treatment, my consent may be withdrawn at any time and understand that I must inform the attending physiotherapist.

_____ Date: _____
Client signature / Designate if client a minor

2) Release and Obtain Information:

I give ZONE Sports Physiotherapy my consent to release/obtain information from the following individuals with respect to my care. I understand that for the duration of my treatment, my consent may be withdrawn at any time and understand that I must inform the attending therapist.

Physician(s) Name: _____

Other (Specify): _____

_____ Date: _____
Client signature / Designate if client a minor

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