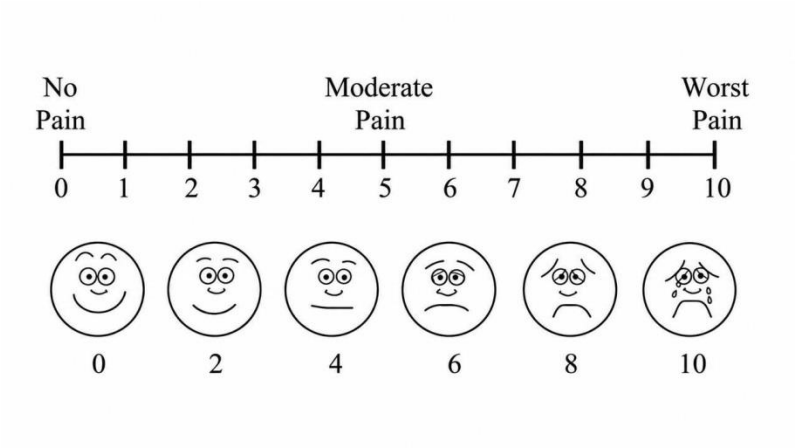
Physiotherapy Consent Form

First Name:	
Last Name:	
DOB:	

Health History

1. History of Present illness:_____
2. Using the following Pain Scale, rate your pain:



3. Past Medical History:_____
4. Current medications:_____
5. Chief Complains:_____
6. Hand dominance:_____

I understand that physiotherapy may include assessment, hands-on treatment, exercise, stretching, and other appropriate therapeutic techniques.

I understand that physiotherapy is intended to improve my condition, function, and comfort, but results cannot be guaranteed. Treatment may cause temporary soreness, discomfort, or aggravation of symptoms. I will inform my physiotherapist if I experience pain, discomfort, or have any concerns during treatment.

I understand that treatment may require exposure or physical contact with the area being assessed or treated. My privacy, dignity, and comfort will be respected at all times.

I have had the opportunity to ask questions and understand the proposed physiotherapy treatment. I understand that I may refuse or stop treatment at any time.

By signing below, I consent to physiotherapy assessment and treatment as deemed appropriate by my physiotherapist.

Signature(please use your First name and Last name): _____ **Date** _____