Client Information and Health History and Consent Form

Client Name: _____ Date: _____

Birth date:____/___/_____ Age:_____

Phone Number:(___)_____-_____E-Mail Address:_____

Home Address:_____

Previous injuries or surgeries: (Please list dates) _____

_____

_____

_____

Other health conditions: (heart, lungs, brain, etc.) _____

_____

List ALL medications you are currently taking: _____

_____

_____

Primary Care Physician: _____ Phone: _____

Orthopedic Physician: _____Phone: _____

Emergency Contact: _____Phone: _____

Legal Guardian Name:_____

Activities you are currently participating in, list hours/week of completion:

_____

I understand that I am participating in a recovery program and am NOT receiving physical therapy treatment. I understand that these services are NOT medically necessary. I understand that these services are being supervised by a licensed physical therapist and if part of the recovery program feels like it is causing me harm, I need to tell the physical therapist or ask that I stop the service.

I understand that if I am not truthful in my medical history and current injuries, I may be putting myself at risk for an adverse reaction to these recovery services (electrical stimulation, vasopneumatic compression, cold therapy, Alter-G treadmill, foam rolling and stretching).

_____ _____

Participant's Signature Date

_____ _____

Legal Guardian's/Parent's Signature Date