Covid–19 Consent Form

I affirm: To the best of my knowledge I have not knowingly come into contact with a confirmed case of Covid-19 or persons close to a confirmed case of Covid-19. I understand that I will be screened(and self-screened through the website) at the time of booking and on arrival as well as requested to verbally update my consent to treatment for every appointment. I understand that if I said yes to any of the screening questions or have any symptoms listed in any capacity whether it is related to Covid-19 or not, that has not been cleared by 811 or my Doctor, my treatment will be discontinued immediately and I will contact Brian Sutherland's office before the scheduled appointment time to discuss how to proceed with future treatment. I understand that while the physiotherapist is following health and safety guidelines outlined by the Physiotherapy College of Nova Scotia and the provincial health officer and all reasonable precautions to clean and disinfect the clinic within the treatment room there are no guarantees that I may not come into contact with Covid-19. I certify that the above information is correct to my knowledge and that I have read and understand all of the above statements and would like to proceed with treatment on this basis.

_____

Signature

PHYSIOTHERAPY ALTERNATIVES

HOW DID YOU HEAR ABOUT ME? _____

NAME_____ D.O.B. _____ M/F

ADDRESS _____ CITY_____ P.C. _____

E-MAIL ADDRESS (OPTIONAL)_____

PHONE (H)_____ (W)_____ FAMILY MD_____

OTHERS YOU WOULD LIKE ME TO CORRESPOND WITH_____

_____

I HEREBY CONSENT TO THE RELEASE OF INFORMATION TO MY FAMILY DOCTOR AND/OR OTHER PRACTITIONERS (AS LISTED ABOVE).

X_____
Signature

PRIVATE GROUP INSURANCE ___ YES ___NO
INSURANCE COMPANY NAME _____

ACTIVE M.V.A. CLAIM ? ____ YES ____ NO
DATE OF ACCIDENT _____

CANCELLATION POLICY - PLEASE GIVE AS MUCH NOTICE AS POSSIBLE FOR CANCELLATION OF APPOINTMENTS. UNLESS THERE IS AN EMERGENCY, YOU (NOT THE INSURANCE COMPANY) WILL BE BILLED FOR MISSED APPOINTMENTS OR INADEQUATE NOTICE.

WITHOUT ADEQUATE NOTICE (LESS THAN 24 HOURS)	**$110.00/$130 MVA**
NO SHOW	**$110.00/$130 MVA**
N.S.F. Cheque	**$30.00**

RESPONSIBILITY FOR PAYMENT: PAYMENT IS BY E TRANSFER PRIOR TO THE SESSION OR CASH AT THE BEGINNING. I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS.

_____20_____ **X**_____

Electronic Health Information:

Client Consent

I understand and agree that my health information may be maintained, at least in part, by Brian Sutherland PT in electronic form and may be transmitted to medical doctors, chiropractors, naturopathic doctors, other physiotherapists, or other practitioners, lawyers and/or insurance companies as required in the course of my treatment. The risks and benefits of maintaining and transmitting by health information in electronic form have been discussed with me**. Please note that for the purposes of this practice, minimal reliance on electronic healthcare record keeping and transmission is utilized.** Some health records may be kept on a password protected, firewall computer system. Fax cover letters are sent with security warnings. Any records which are maintained on hard drive, for example, are completely erased and the hard drive reformatted and/or destroyed when the computer carrying the data system is replaced.

Privacy concerns can be addressed to the privacy officer, Brian Sutherland PT at 902-462-6488 or via the contact section on the website at www.briansutherland.ca.

_____

Name

_____

Date

Date: _____

Functional Capacity Questionnaire

I am attempting to get an idea about your present functional abilities. This form is designed to help me quantify your limitations, at the present time, and will allow me to measure your improvement as time progresses.

To this end, I ask you to list up to 5 activities which are important to you that you are unable to do, or have difficulty with, as a result of your injury. Examples may include things such as sleeping, walking, sporting activities, work related, hobbies, etc.

Please list the activity (ies), and circle a score of 0 to 10 of the difficulty with each, with a score of 0 meaning unable to perform, and 10 meaning full pain-free function (able to perform at pre-injury level)

Activity	Unable to Perform										Full Pain-free Function
1. _____	0	1	2	3	4	5	6	7	8	9	10
2. _____	0	1	2	3	4	5	6	7	8	9	10
3. _____	0	1	2	3	4	5	6	7	8	9	10
4. _____	0	1	2	3	4	5	6	7	8	9	10
5. _____	0	1	2	3	4	5	6	7	8	9	10

----------Please do Not Write below this line----------

Activity	Date	Date	Date	Date	Date

This form designed by Micheal Richie

INFORMED CONSENT

Please note that this is a holistic manual therapy practice primarily utilizing but not limited to non traditional methods. Due to this, I will be assessing and treating the whole person **using the hands** prior to treatment. I will be looking for tissue restriction that is keeping you from getting better. The areas of examination and treatment may not be exactly where you are feeling your pain. The area of pain and the location of the cause are not always the same especially with chronic pain. Although the areas of pain will be assessed, I will be looking, as much as possible, for the areas that are causing the pain.

This could include exposure, assessment and or treatment of the lower abdomen, back or ribs for example. I will explain what I am doing and finding as I examine you. If you have any questions or concerns whatsoever, please do not hesitate to ask at any time before, during or after the assessment or treatment if you do not understand my explanations. If you have concerns with regards to touch, I need to know this **before** the examination begins.

Some people may feel discomfort as a result of limb movement and/or connective tissue release with assessment and/or treatment. Research has shown that tissue memory involving biochemicals such as lactic acid, neurotransmitters and other waste products can be released with body work. This is not unusual and can sometimes result in usually temporary discomfort as the tissues clear. Let me know if you have questions or concerns about this. **Please note that you have the right to stop assessment and/or treatment at any time if you are uncomfortable.**

Your signature below indicates that you have read and have understood all of the above.

_____

patient signature

_____

practitioner signature

_____

date

PLEASE CAREFULLY CONSIDER THESE CONDITIONS AND
MARK ANY THAT APPLY TO YOU

____Dizziness (especially from neck movement)
____Falling for no reason
____Heavy feet, hard to walk
____Tingling face/lips/tongue
____Bleeding disorder
____Fever at the same time as this condition
____Unexplained weight loss
____Diabetes
____Fewer than 3 calcium products/day
____Epilepsy
____Steroids
____Bowel or bladder problems
____Heart condition
____Numbness or pain of genitals
____Bite plate from dentist
____Infectious condition
____Shortness of breath or asthma
____Rheumatoid arthritis
____Double Vision
____Clumsy/numb feet or hands
____Recent throat infection or thrush
____Uncoordinated swallowing
____Bone disease including malformed bones
____Night pain accompanied by drenching sweat
____Scoliosis
____Osteoporosis
____Cancer past or present
____Serious allergies/environmental sensitivities
____Previous bad reaction to physiotherapy/chiropractic/osteopathy
____Pain at bottom of tailbone
____Metal implants/staples/IUD
____Face pain/TMJ pain/clicking jaw
____Change in hand color or temperature
____Pregnancy (or trying to get pregnant)

Are you off work with this problem? Yes _____No _____
Have you recently had treatment for this same condition? Yes _____No _____
Date:

Patient's Signature:_____PT Signature_____