80 Mary Street,
Clinton ON, N0M 1L0
T: 519.606.7777
F: 519.606.7750
Alexis Hewitt CAT(C)

THE CHIROPRACTIC HOUSE & CO,
Athletic Therapy Patient Intake Form

Date: _____

Last Name		First Name	
Address	City	Province	Postal Code
Home Phone	Cell Phone	Email Address	
Date of Birth	Sex ☐ M ☐ F ☐ Undisclosed	Occupation	
Emergency Contact Name	Emergency Contact Number	Relationship	
Reason for Visit?			

Medical History

Please Circle YES or NO to if you have or have had the following:					
Heart Disease/Conditions	Yes	No	Osteoarthritis	Yes	No
Rheumatoid Arthritis	Yes	No	High Blood Pressure	Yes	No
Stroke	Yes	No	Low Blood Pressure	Yes	No
Epilepsy or Convulsions	Yes	No	Diabetes	Yes	No
Kidney or Bladder Conditions	Yes	No	Tumor or Cancer	Yes	No
Respiratory Conditions	Yes	No	Stomach/Intestinal Disorders	Yes	No
Surgical Plates or Pins	Yes	No	Osteoporosis	Yes	No
Thyroid Disorders	Yes	No	Previous or current Pregnancy	Yes	No
Pacemaker	Yes	No			

Other (Please List): _____ _____ _____	Medications (Please List): _____ _____ _____
Surgeries (Please List): _____ _____ _____	Allergies (Please List): _____ _____ _____

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Consent to Athletic Therapy Assessment and Treatment

I understand that the primary goals of Athletic Therapy treatments are to help reduce my pain and improve my performance, mobility, strength, endurance, function and quality of life. In order to achieve these goals, it is necessary for my Athletic Therapist to perform a physical assessment to enable them to develop an individualized treatment plan.

I understand that Athletic Therapy treatments may include individualized exercise prescription and various forms of manual therapy techniques such as mobilization, PNF and stretches. Other treatments may include heat, ice, and therapeutic/performance taping.

While individualized treatment plans are formulated to benefit me, I understand that there are small possibilities of risks or complications that may result from the above listed treatments. I understand that I will have the opportunity to discuss these risks and the nature and purposes of all my treatments with my treatment provider and consent to treatment at that time. I am aware that I may withdraw this consent and discontinue treatment at any time.

Privacy and Sharing of Information

I authorize AW Athletic Therapy and its associated health professionals to collect my personal and medical information as documented on the Patient Intake Form. I understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

By signing below, I understand the conditions and information provided above and I give my consent to undergo Athletic Therapy assessment and treatment. I acknowledge that all of the above information is true and correct. If at any time the above information changes, I am aware that I must inform my Therapist immediately.

Patient Signature: _____ Date: _____

Parent Signature (if under the age of 18): _____ Date: _____