INFORMED CONSENT

Physio

PATIENT AUTHORIZATION

I hereby authorize and grant permision to ______________________________ (your physio's name)

at **PhyisoEgypt**, to carry out any assessment and examination, procedures, and treatments as may be necessary to assess and treat my condition or injury.

The above named Physiotherapist has agreed to provide me with understandable:
Information on:

- My diagnosis, as known
- The treatment being suggested
- Significant risks, benefits of treatment, and possible alternatives to this treatment
- Reasonable additional procedures which may be necessary
- The potential risks of foregoing the suggested care

I hereby authorize and grant permission to the above-named Physiotherapist to communicate with any health care professional that rehabilitation of my condition may indicate.

I hereby authorize and grant permission to the above-named Physiotherapist to release information regarding my condition and my ability to return to normal activity or work to my insurance company/employer/lawyer or their representative.

I, ____ , understand the conditions and information as

verbally provided and voluntarily give my consent to the above authorizations.

Date ____________________

Signature ____________________

REGISTRATION INFORMATION

Physio

Patient Name: ______________________________ Date of Birth: ____________

Age: ____________ E-mail: ______________________________

Home Address: ______________________________

Home Phone Number: ____________________

Cell phone Number: ____________________

Female ☐ Male ☐

Patient employed by: ____________________ Business address: ____________________

Occupation: ____________________ Business phone #: ____________________

Medical Insurance company: ____________________ ID #: ____________________

In case of emergency, who should be notified: ______________________________

Phone #: ____________________

If patient is a minor:

Guardian Name: ______________________________

Home address: ______________________________

Cell phone number: ____________________

work phone number: ____________________

Whom may we thank for referring you to us?

____

* I hereby authorize Physio to perform any physiotherapy treatment and evaluation, which deemed necessary for my health care.

Date	Signature of patient (Or, responsible party if patient is a minor or unable to sign)
____________	______________________________

MEDICAL HISTORY

Physio

Patient's Name: ______________________ Age: ________ Date: ___________

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you. Thank you!

1. ALLERGIES: List any medication(s) you are allergic to: ______________________

2. Are you latex sensitive? Yes ☐ No ☐ List any other allergies we should know about ______________________

3. Please check any of the following whose care you're under:

- ☐ Medical doctor (MD)
- ☐ Dentist
- ☐ Physical Therapist
- ☐ Other
- ☐ Osteopath
- ☐ Psychiatrist/Psychologist
- ☐ Chiropractor

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.):

____

____

4. Have you EVER been diagnosed as having any of the following conditions? (Please circle yes or no)

Yes ☐ No ☐ Cancer If Yes, describe what kind: ______________________
Yes ☐ No ☐ Heart Problems
Yes ☐ No ☐ High blood pressure
Yes ☐ No ☐ Circulation problems
Yes ☐ No ☐ Asthma
Yes ☐ No ☐ Emphysema/Bronchitis
Yes ☐ No ☐ Chemical dependency (i.e., alcoholism)
Yes ☐ No ☐ Thyroid problems
Yes ☐ No ☐ Diabetes
Yes ☐ No ☐ Multiple sclerosis
Yes ☐ No ☐ Osteoporosis
Yes ☐ No ☐ Rheumatoid arthritis
Yes ☐ No ☐ Other arthritic conditions
Yes ☐ No ☐ Depression
Yes ☐ No ☐ Hepatitis
Yes ☐ No ☐ Tuberculosis
Yes ☐ No ☐ Stroke
Yes ☐ No ☐ Kidney disease
Yes ☐ No ☐ Anemia
Yes ☐ No ☐ Epilepsy
Yes ☐ No ☐ Other: ______________________

For Office Use

5. FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes ☐ No ☐

6. How much caffeinated coffee or caffeine containing beverages do you drink per day? ______________________

7. How many packs of cigarettes do you smoke a day? ______________________

8. How many days per week do you drink alcohol? ______________________

MEDICAL HISTORY

Physio

9. Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Date	Reason For Surgery/hospitalization	Date	Reason For Surgery/hospitalization
1. ______	______	2. ______	______

10. Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

Date	Injury	Date	Injury
1. ______	______	2. ______	______

11. Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

- Yes ☐ No ☐ Diabetes
- Yes ☐ No ☐ Tuberculosis
- Yes ☐ No ☐ Heart disease
- Yes ☐ No ☐ High blood pressure
- Yes ☐ No ☐ Stroke
- Yes ☐ No ☐ Kidney disease
- Yes ☐ No ☐ Alcoholism (chemical dependency)
- Yes ☐ No ☐ Cancer
- Yes ☐ No ☐ Arthritis
- Yes ☐ No ☐ Anemia
- Yes ☐ No ☐ Headaches
- Yes ☐ No ☐ Epilepsy
- Yes ☐ No ☐ Mental illness

12. Which of the following OVER-THE-COUNTER medications have you taken in the last week?

- Yes ☐ No ☐ Paracetamol
- Yes ☐ No ☐ Ibuprofen
- Yes ☐ No ☐ Laxatives
- Yes ☐ No ☐ Decongestants
- Yes ☐ No ☐ Antihistamines
- Yes ☐ No ☐ Antacid
- Yes ☐ No ☐ Vitamins/mineral supplements
- Yes ☐ No ☐ Other______

For Office Use

14. Please list any PRESCRIPTION medication you are currently taking:

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______

Therapist Signature ______ Date ______ Patient Signature ______ Date ______

REHABILITATION SCREENING

Physio

Patient's Name: ______________________ **Age:** __________ **Date:** __________

Your Physio: ______________________

Please complete the following form to help us develop an individualized treatment plan for you.

1. Chief complaint (why are you at Physio today)? ______________________

2. How long have you had this problem/injury ?______________________

a. Date it worsened (if applicable): ______________________

3. How did your current problem begin? lifting ☐ twisting ☐ falling ☐ motor vehicle accident ☐ unknown ☐

bending ☐ other ☐ : ______________________

4. Your symptoms are: Getting better ☐ Getting worse ☐ Staying the same ☐

5. Have you had any tests performed for this problem (X-ray, MRI, labs, etc.) ?______________________

Results? ______________________

6. Have you recently noted any of the following: (check all that apply)

☐ Headaches	☐ Fever/Chills/Sweats	☐ Nausea/Vomiting	☐ Weight loss/gain
☐ Difficulty maintaining balance	☐ Shortness of breath	☐ Numbness/tingling	☐ Muscle weakness
☐ Dizziness/lightheaded	☐ Heartburn/indigestion	☐ Difficulty swallowing	☐ cough
☐ changes in bowel/bladder	☐ constipation	☐ Diarrhea	☐ Falls
☐ Fainting	☐ Fatigue		

7. Please mark the areas where you have seen a decline in your abilities with your most recent condition:

☐ Coughing/Sneezing	☐ Driving	☐ Lifting	☐ Balance
☐ Sleeping	☐ Rising from sitting	☐ Carrying Objects	☐ Steps/Stairs
☐ Lying down	☐ Standing	☐ Reaching/Lifting overhead	☐ Exercise routine
☐ Getting in/out of bed	☐ Walking	☐ Turning head/trunk	☐ Work duties
☐ Coughing/Sneezing	☐ Bending	☐ Dressing/Grooming	☐ Home duties

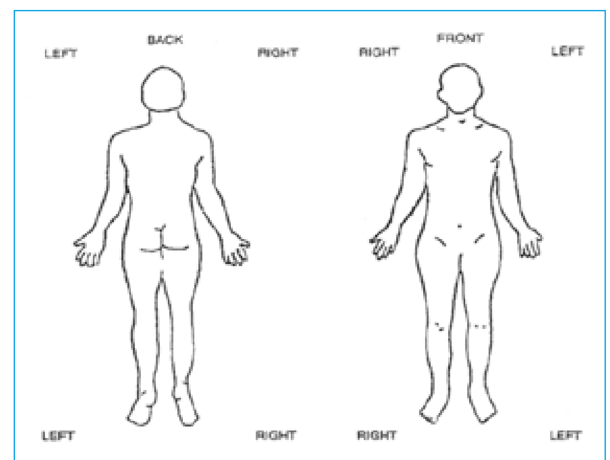
☐ Other: ______________________

8. Have you experienced similar symptoms before? Yes ☐ No ☐

a. Indicate on the body diagrams where your symptoms occur:

Signs associated with your chief complaint

☐ Aching	☐ Edema (swelling)
☐ Stabbing	☐ Redness
☐ Pins & needles	☐ Loss of movement
☐ Numbness	☐ Muscle spasm
☐ Burning	☐ Bruising
☐ Warmth	☐ Other ______________



REHABILITATION SCREENING

Physio

b. Rate your pain using the following scale, with one being the least amount of pain and 10 being very severe pain:

During rest:	1	2	3	4	5	6	7	8	9	10
During activity:	1	2	3	4	5	6	7	8	9	10

9. Do you partake in any physical exercise (before your injury) and how often? ______________________________

____

10. Have you ever been diagnosed with any of the following?

- ☐ Cardiac Problems
- ☐ Diabetes
- ☐ Asthma
- ☐ Infectious Disease
- ☐ Hypertension
- ☐ Osteoarthritis
- ☐ Orthopedic Problems
- ☐ Autoimmune Disease
- ☐ Pacemaker
- ☐ Rheumatoid Arthritis
- ☐ GI problems
- ☐ Stroke/TIA
- ☐ Cancer
- ☐ Seizures
- ☐ Multiple Sclerosis
- ☐ Open wound
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Drug/Alcohol Dependency

11. Have you ever had a broken bone or fracture? Yes ☐ No ☐

If yes, which body part: ______________________________ When: ______________________________

12. Please list any major surgeries with dates: ______________________________

____

____

13. Any previous physical therapy, chiropractic care or other treatment? Yes ☐ No ☐

14. Do you smoke? Yes ☐ No ☐ If yes, number of packs/day? ______________

15. Are you pregnant? Yes ☐ No ☐

16. What are your goals for physical therapy?

____

____

17. Is there anything else you'd like your Physio to know?

____

____

____

____