FOREST HILL PHYSIOTHERAPY & HEALTH CENTRE

361 Eglinton Ave West • Toronto, ON • M5N 1A3 • Tel: 416.551.7111

Physiotherapy Informed Consent Form

Please read the following statements and sign below.

- I must inform this office of any other practitioner (other than physicians) that I am currently seeing.
- I must inform my physical therapist of any contagious or infectious condition that I might have.
- I understand that I need to express all of my health concerns (both current and past) to my therapist.
- I consent to an examination and treatment performed by a licensed physiotherapist.

The results will assist the physiotherapist in determining the appropriate physical treatment to meet my specific needs and goals. I understand that my treatment in this clinic may involve the use of:

- Various physical and electrical modalities
- Acupuncture
- Stretching or mobilization of joints and tissues
- Exercise programs aimed at mobility, strength and function

- I understand that discomfort may occur following treatment. The therapist will contact my physician should the presence of symptoms represent any potential risks. I understand that it is my responsibility to contact a therapist in the clinic should I experience any unusual symptoms.
- I understand that if at any time I am not comfortable with, and/or do not understand the purpose of any treatment procedure I will ask the physiotherapist for further explanation/information. I understand that I may stop the assessment or treatment procedure at any time, during or after a session.
- I understand that the Clinic will send an initial assessment and follow-up report(s) as appropriate to the licensed practitioner who referred me to the clinic for treatment.
- I have read, understood, and had opportunity to discuss the Client Information form

I have read and fully understand all of the above information and give my permission to be assessed and /or treated at Forest Hill Physiotherapy & Health Centre.

My signature below indicates my understanding of all of the above information.

______________________________	______________________________
Name of Client	Date
______________________________	______________________________
Signature of Client	Witness Signature

If **under 16 years of age**, the following section of the consent form must be completed by a parent or guardian before treatment can be initiated.

______________________________	______________________________
Printed name of parent/guardian	Date
______________________________	______________________________
Signature of parent/ guardian	Witness Signature