

# ActivFit Sports Therapy

Burnaby - Suite 104 – 3999 Henning Drive, West Vancouver – 660 Clyde Ave

Telephone: 778-839-035

Email: [Becky@ActivFit.ca](mailto:Becky@ActivFit.ca)

---

## CONSENT FOR EXAMINATION, TREATMENT AND RELEASE OF PATIENT INFORMATION

---

I, the undersigned, do hereby consent to examination/treatment at ActivFit Sports Therapy, which may include modalities being electrical or manual therapy as well as exercise prescription including flexibility, stability, and strength training exercises.

I also authorize ActivFit Sports Therapy to release medical information to Physicians, I.C.B.C., Lawyers and/or Insurance Companies that are directly involved in my care.

I further authorize ActivFit Sports Therapy to obtain medical records regarding my diagnosed injury.

### ***Expectations:***

*1. If I am not able to attend a scheduled appointment, 24 hour cancellation notice is required. I understand if I fail to provide sufficient notice I will be responsible for full payment of the missed appointment.*

*2. I will be provided with a Home Program with stretching and strengthening exercises and I am expected to complete the program, as recommended by ActivFit Sports Therapy.*

I understand and agree to the above.

Dated this \_\_\_\_\_ day of \_\_\_\_\_ (month) \_\_\_\_\_ (year)

---

Signature (Please Print)

---

Signature

**Telephone: 778-839-7035**

**[Becky@ActivFit.ca](mailto:Becky@ActivFit.ca)**

# ActivFit Sports Therapy

Burnaby - Suite 104 – 3999 Henning Drive, West Vancouver – 660 Clyde

Telephone: 778-839-035

Email: [Becky@ActivFit.ca](mailto:Becky@ActivFit.ca)

---

## MEDICAL HISTORY/LIABILITY: INFORMED CONSENT FORM

---

### Past Medical History

- High Blood Pressure
- Low Blood Pressure
- Heart Disease (Which one?)
- Heart murmur
- Pacemaker
- Other heart problems
- Lung Disease (Which one?)
- Diabetes (Type 1 or 2)
- Epilepsy
- Neurological Disorder
- Syncope (dizzy spells)
- Arthritis (What kind?)
- Allergies/Medications
- Other Medical Conditions
- Medications you are currently taking

### Present Signs/Symptoms

- Heart palpitations
- Shortness of breath
- Chest Pains
- Extremity or Abdominal Pain
- Coughing upon exertion (P)
- Coughing up blood
- Back pain (upper/mid/lower)
- Stiff/painful/swollen joints
- Paresthesia/ Loss of function
- Muscle,tendon,ligament,bone
- Major Surgery
- Other Signs or Symptoms

### Details:

---

---

---

### INFORMED CONSENT

1. The medical history questions are answered to the best of my knowledge. I understand and I am aware that electrical equipment as well as strength and flexibility exercises, including the use of the equipment, is a potentially harmful activity. I also understand that I am voluntarily participating in these activities and using the equipment and modalities with all the knowledge of dangers involved. I hereby agree to expressly assume and accept any and all risks of harmful activities (Please Initial) \_\_\_\_\_.

2. I hereby waive any and all claims that I may have or may in the future have against ActivFit Sports Therapy, and release ActivFit Sports Therapy r from any and all liability for any loss, damage, injury, or expense that I may suffer. (Please Initial)\_\_\_\_\_

I hereby affirm that I have read and fully understand the above.

---

Signature (Please Print)

---

Signature

Telephone: 778-839-7035

[Becky@ActivFit.ca](mailto:Becky@ActivFit.ca)

# ActivFit Sports Therapy

Burnaby - Suite 104 – 3999 Henning Drive, West Vancouver – 660 Clyde

Telephone: 778-839-035

Email: [Becky@ActivFit.ca](mailto:Becky@ActivFit.ca)

---

## CLIENT CONTACT INFORMATION

---

Welcome to ActivFit Sports Therapy. Please take a minute to complete this information form.

Name:

\_\_\_\_\_

FIRST

\_\_\_\_\_

LAST

Address:

\_\_\_\_\_

CITY

\_\_\_\_\_

POSTAL

\_\_\_\_\_

CODE

Telephone:

\_\_\_\_\_

HOME

\_\_\_\_\_

WORK

\_\_\_\_\_

CELL

e-mail:

\_\_\_\_\_

Your email will **only** be used to send you a clinic newsletter.

date of birth: \_\_\_\_\_

DD-MM-YY

Occupation: \_\_\_\_\_

To help us spend our marketing money wisely, please let us know how you heard about us.

\_\_\_\_\_.

What brings you to seek Athletic Therapy? For example, headaches, car accident, pain, immobility, fitness.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you received athletic therapy; massage therapy; physiotherapy; chiropractic care this year?

If yes, when were you last treated? \_\_\_\_\_

Name of previous practitioner: \_\_\_\_\_