Name:	Family Physician/ Location: DR.	Date of Birth: (M/D/YR)
Mailing Address / Postal Code:		
Home Telephone Number:	Cell Phone Number:	
Emergency contact and phone number:	Email:	

Who referred you? **Referral Date: (M/D/YR)_____**

- Doctor (Provide name)
- Friend/ Family Member(Provide name)

Where did you get our phone number?

- Phone Book
- Referral pad
- Other :_____
- Business Card
- Internet

CONSENT:
I hereby consent to the assessment by the Physiotherapy staff of Impact Physiotherapy & Performance.

Date: _____ Signature: _____ Witness: _____

I hereby consent to the Plan of Care as explained by the Physiotherapist.
I understand the possible risks and benefits of this treatment and that any changes to this plan of care will be discussed with me.
I also understand that this clinic uses support personnel (trained Physiotherapy Assistants) to assist in carrying out some aspects of treatment but this is always done under the direction of the Physiotherapist.
It is my right to withdraw my consent to treatment at any time.

Date: _____ Signature: _____ Witness: _____