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**Physiotherapy Patient Consent Form**

**Patient Intake Form**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Surname: | | |  | | Given Name: | |  | | |
| Home Address: | | | | | Email Address: | |  | | |
|  | | | | | Mobile: | |  | | |
| City: |  | | | | Occupation: | |  | | |
| Post Code: | | | |  | Date of Birth: | |  | | |
| Emergency Contact 1 : | | | | | | | | | |
| Name: | |  | | | Relationship: |  | | Phone: |  |
| Emergency Contact 2: | | | | | | | | | |
| Name: | |  | | | Relationship: |  | | Phone: |  |

**Patient Details**

|  |
| --- |
| Presenting condition (please give brief details): |
|  |
| Past medical history (medical and previous injuries): |
|  |
| Allergies: |
|  |

**Consent**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give consent to receive physiotherapy assessment and treatment from Cancer Education x Physio Friend.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_