Therapy4Sports

ASSESSMENT FORM

- Name:
- Date of Birth:
- Address:
- Contact phone number
- Email address:
- Occupation:
- Sport:
- Where did you hear about therapy4sports?
- Are you claiming on insurance? If so what is your insurance policy number?
- Please briefly explain why you require treatment.

Please read through carefully, sign and date below to continue with assessment.

- To promote the safety and benefit of your participation in therapy4sports it is important that you fully disclose your personal health history, any medications you are taking, and any symptoms you may be experiencing.
- Any information will be kept confidential to the extent provided by law. You will be encouraged to allow us to share this information with your physician or primary care provider in an attempt to diagnose or treat a current disease or reduce your risk of developing a more serious medical condition. No identifiable information will be released or revealed to any other party without your written consent. You may be asked, however, to allow certain information (from which your identity is removed) to be used for statistical analysis or research purposes.
- I understand my responsibility in the treatment in which I will be engaged. I accept the risks, rules, and regulations set forth. Knowing these, and having had an opportunity to ask questions which have been answered to my satisfaction, I consent to participate in treatment. I have provided all information to the best of my knowledge and will inform my therapist if there are any changes.

Signature ________________________________ Date________________