ESSENTIAL PHYSICAL THERAPY AND WELLNESS

PLEASE LIST ALL THE MEDICATIONS, VITAMINS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING.

Medications, Vitamins, Supplements:	Method (circle one)	Dosage	Frequency (circle one)
	Oral Patch Inhaler Injection Other:		1x/day 2x/day 3x/day Other:
	Oral Patch Inhaler Injection Other:		1x/day 2x/day 3x/day Other:
	Oral Patch Inhaler Injection Other:		1x/day 2x/day 3x/day Other:
	Oral Patch Inhaler Injection Other:		1x/day 2x/day 3x/day Other:
	Oral Patch Inhaler Injection Other:		1x/day 2x/day 3x/day Other:
	Oral Patch Inhaler Injection Other:		1x/day 2x/day 3x/day Other:

I hereby consent to evaluation and/or treatment of my condition by a licensed physical therapist employed by Essential PT and Wellness. I am aware that the physical therapist will inform me of the expected benefits and possible discomfort, which may result from skilled physical therapy care.

I understand that to evaluate my condition it may be necessary to perform manual physical therapy and therapeutic exercise. I am also aware that there is not a guarantee that the proposed course of treatment will improve my condition and that it is possible, although unlikely, that the cause of treatment may cause additional pain or discomfort or aggravate my condition. I confirm that I have read and fully understand this consent form.

Patient's Initials:_____

PATIENT (OR PARENT/LEGAL GUARDIAN SIGNATURE):_____DATE:_____

FORM HAS BEEN READ AND REVIEWED BY THERAPIST: YES NO PT INITIALS:_____