OFF-SEASON
SPORTS & PHYSICAL THERAPY

***Confidential Patient Information***

**Gait Scan Intake Paper work**

** Please complete **all** of the below **

Today's Date: _____

Your Full Name: _____

What do you prefer to be called: _____ Pronouns: _____

Address: _____

_____

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____ E-Mail Address:_____

Date of Birth: _____ Current Age: _____ Male / Female Gender Identity_____

Your Shoe Size:_____ Your Weight:_____

## Your Signature

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes to the information I have provided. If you are unable to keep your scheduled appointment, please contact us with 24 hour notice. If you are more than 15 minutes late you may be asked to reschedule. There is a $45 fee for no-show or cancelation with less than 24 hour notice.

Signature:_____ Date:_____

## Consent of Treatment

I,_____, hereby understand the terms and conditions of this document. I am authorizing all certified/insured staff of OFF-SEASON Sports and Physical Therapy to administer necessary treatment protocol(s). I understand that health and/or accident insurance policies are an arrangement between the insurance carrier(s) and myself. I also am aware that there is no guarantee to the results that may be obtained.

_____ _____

Signature: Patient or Legal Guardian Date