

NEW PATIENT / RETURNING PATIENT FORM

First name: _____ Last name: _____

Date of birth: ___/___/_____ Title: Mr/Mrs/Ms/ Miss Occupation: _____

Address: _____ Suburb: _____ Post code: _____

Phone: Home _____ Mobile _____ Work _____

Email Address: _____ Pensioner: YES No

Private Health Fund: Yes No Fund Name: _____ Patient No On Card _____

Who may we thank for referring you? _____

GP Name and address: _____

Are you pregnant? Yes No Number & ages of children: _____

Marital status: M S W D Defacto Same Sex Emergency Contact: _____

Do you give us permission to share information regarding treatment and your health with your treating doctor? _____

Would you like SMS reminders? (Please DO NOT reply to these as they are computer generated) Yes No

Would you like to receive emailed Newsletters in the future from this practice? Yes No

Area to be treated: _____ Date of injury: _____

Current Symptoms:

Often an accumulation of life's stressors can lead to health problems and symptoms. As health practitioners, we attempt to understand the reasons for which our bodies express these symptoms.

| Please list your symptoms according to severity | How severe? 0-10/10? 0: No pain 10: Worst pain | When did it start? | Have you had it previously? If so, when? | What brought it on? | % of the time it is present? | Aggravating activities? |
|---|---|--------------------|---|---------------------|------------------------------|-------------------------|
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What kind of symptoms? Sharp / Dull / Throbbing / Ache / Numbness / Shooting / Radiating or referred / Other: _____

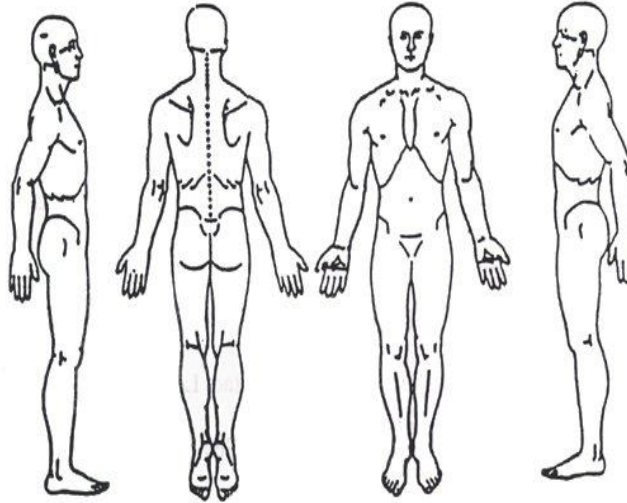
Have the symptoms: Improved? Worsened? Not changed?

What eases them? _____

Are you currently: Off work on suitable duties Pre-injuries

Please indicate on the diagram below where your symptoms are:

Pain = X Shooting/Radiating = >>> Tingling / Numbness = ///



Health History

Height= ____cm

Weight (approximately) = ____kg

Implants:

- Pacemaker IUD Stent

Family History:

Stroke / Heart Disease / Arthritis / Vascular Disease / Cancer / Genetic Disease / Auto immune Disease / Other _____

Medications and/or supplements: _____

Medical History:

| | | |
|--|-------|---------------------|
| 1- Previous Accidents and/or injuries ie: Motor Vehicle Accident, work related or other: | What: | When approximately: |
| 2- Illness: | | |
| 3- Surgeries | | |

Smoke: Yes / No / Previously; Number of cigarettes:____/day Alcohol: No.____/week
 Coffee/Tea: No.____/day Water: No. of 250mL/ Glasses____/day
 Soft Drink: No. Cans/Glasses____/day

Physical Exercise for > 20-30min: _____/week.

Please describe your sport/ exercise routine: ie swimming/cycling/running/golfing/bowling _____

Privacy Consent

In order to provide you with the best quality treatment, and consequently, outcomes, we are required to collect some personal and medical information from you. This information will also be used for administrative purposes, including billing, within the practice when it is necessary to pass on the information to other clinicians for ongoing treatment and care and to your doctor or other treatment providers.

In the case of an insurance claim, it may be necessary to disclose and/or collect information which affects your treatment and return to work.

If you are attending our practice under a **WorkCover Compensation Claim**, please be aware that you are responsible for payment of your consultation and any supplied equipment on the day of your appointment. Please keep your receipt and send it through to your Claims Manager for payment.

As we strive to provide a quality service for you, we use a pre-booked appointment schedule for all our patients. Therefore, we use a **24 hour cancellation policy**. If we do not receive a 24-hour notice prior to cancelling an appointment (depending on the circumstances) our policy is to charge a nominal fee of \$75.00 which the patient is liable to pay. In the case of a Work Cover Compensation claim or CTP, you are liable to pay not the insurer.

I give permission to destroy my records after 7 years, or as recommended by the A.P.A quality endorsed program.

Please sign below to show you acknowledge these policies.

Name: _____

Signed _____ Date: _____

Informed Consent

As members of the Australian Physiotherapy Association, we strive to provide you with the best evidence based treatments. We are also required to undertake regular professional development courses in order to maintain and improve our competencies.

Some people may experience some mild soreness for 24-48 hours after treatments, especially when their body is unwinding. This is a normal sign of change, as may occur after exercise or stretching.

Should you have any questions, please feel free to ask us.