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: _____

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?

What kind of symptoms? Sharp / Dull / Throbbing / Ache / Numbness / Shooting / Radiating or referred / Other_____

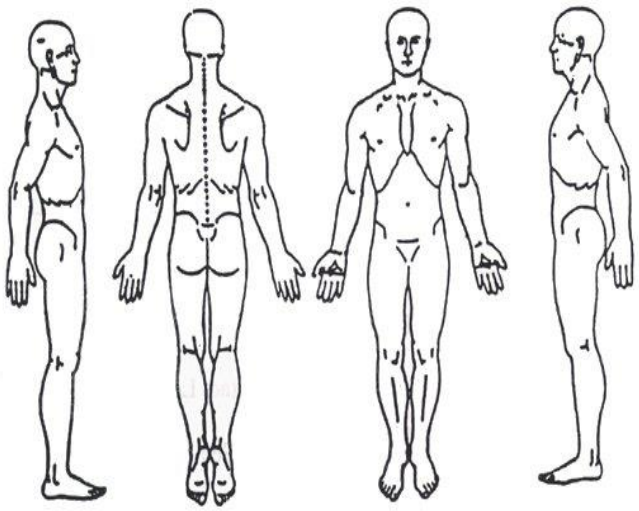
Have the symptoms: ☐ Improved? ☐ Worsened? ☐Not changed?

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

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.

As we strive to provide a quality service for you, we use a pre-booked appointment schedule. Therefore, we use a **24 hour cancellation policy**. In the event that 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 50% of your treatment cost, or your health fund rebate.

If you are attending our practice under a **WorkCover Compensation Claim**, please be aware that if your Compensation Claim is denied with the preferred Insurance Company, you will be fully liable for your treatment costs.

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: _____

*** **N.B:** If you are a **BUPA** member, would you prefer that your medical information is kept private in the event of an audit? □ Yes □ No

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.