Welcome to

Institute of Sports and Spines

Physiotherapy New Patient Information Form

Title:_____ Name:_____ Middle Initial/s:____ Surname:_____

Home Address: _____ Suburb: _____ Postcode: _____

D.O.B._____ **Phone:** Home:_____ Work:_____ Mob:_____

*If you are a **current patient** of Institute of Sports and Spines, please skip to **'Reason for Visit' section below.***

E-mail address: _____

Private Health Fund: _____ Memb No. _____ No. on Card ___

Medical Practitioner's (GP) Name: _____ Phone: _____

Next of Kin/Emergency Contact:_____ Relationship: _____ Ph: _____

Name of person who referred you to us or how did you hear about us?_____

What is your occupation or major daily activity? _____

Hobbies / Sports / Specific Health interests: _____

Do you exercise regularly? If so please give details: _____

I would like to receive marketing emails from Institute of Sports and Spines ☐ Yes ☐ No

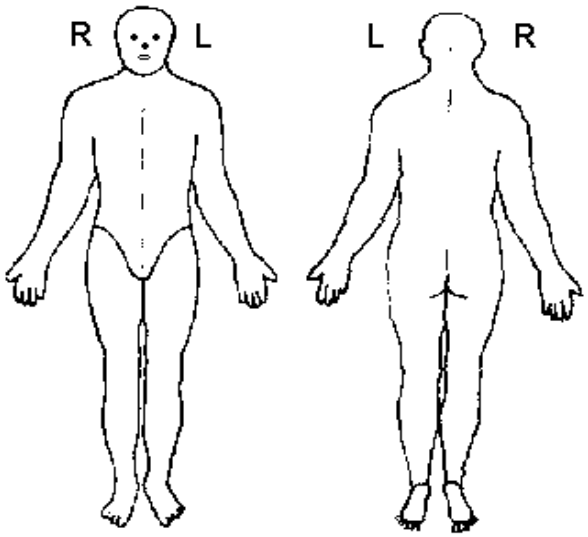
REASON FOR VISIT: _____

Headaches ☐ Yes ☐ No Dizziness ☐ Yes ☐ No

Please indicate the approximate areas on the diagrams:

Pain - XXXX Pins & Needles - \\\\\\\\\\

Numbness - 000000 Stiffness +++++



Please indicate the level of pain you are suffering.

0_____|_____**10**

How would you describe the pain/problem?

_____

_____

When and how did the problem start? _____

Does it re-occur? ☐ Yes ☐ No When and how often?_____

Is the pain worse: ☐ Morning ☐ Evening ☐ During the night Does the pain wake you at night? ☐ Yes ☐ No

Does anything aggravate the pain? ☐ Lying ☐ Standing ☐ Sitting ☐ Movement ☐ Other _____

Does anything relieve the condition? ☐ Yes ☐ No If yes please explain_____

Have you taken any form of pain killer prior to this treatment? _____

What treatment have you had for this condition? _____

What goals do you hope to achieve with treatment? _____

Are you good at maintaining exercises and routines or do you need support? _____

What activities cause you pain? What do you avoid because of the potential for pain or restriction? What would be good benchmarks to use to assess progress?_____

Please fill in page 2-

Have you had any scans prior to your visit? If so, where? _____

How many cigarettes per day do you smoke? _____ How many previously and when did you quit? _____

Recent change in? ☐ Weight ☐ Vision ☐ Hearing ☐ Taste ☐ Smell Please List: _____

Have you had or do you have existing ailments (If so please give details):-

□ Fractures/ Dislocations _____
□ Major Accident's _____
□ Medical Tests / Blood tests _____
□Surgery_____
□ X-rays _____
□ Medication _____
□ Illness / Infection / fever_____
□ Smoking / Drinking_____
□ Recent GP visit _____
□ Other _____

Have you previously, or do you currently experience any of the following conditions?

□ Are you pregnant	□ Allergies	□ Stroke / DVT	□ Blood/Heart Disorders
□ Migraines	□ Cancer	□ Epilepsy	□ Auto-Immune Disorder
□ Bowel/Bladder	□ Digestive	□ Sexual Dysfunction	□ Thyroid Disorders
□ Stress	□ Anxiety	□ Emotional Disorders	□ Insomnia

Please give details:_____

Do you have a family history of □ Stroke □ Heart/ Blood disorders □ Cancer / Malignancy □ Diabetes □ Other Please List _____

Physiotherapy Consent To Treatment – Patient Information

Physiotherapy involves many different types of physical evaluation and treatment. As with all forms of medical treatment, there are benefits and risks involved. The physical response to treatment varies and cannot be predicted, as every individual is different. There is no guarantee that treatment will help your condition(s) and there is a risk of some discomfort or aggravation of the existing condition(s). During your visit(s), it may be necessary to expose and touch the area in need of treatment. It is always our intention to respect your privacy and to protect your modesty.

By signing this document, I hereby consent to evaluation and treatment as deemed appropriate by the treating physiotherapist. The physiotherapist will explain the findings, diagnosis and treatment recommendations with me. I understand that my treatment in this clinic may involve: Manual Therapy (Stretching, mobilisation and manipulation of joints and tissues),Neuromuscular and Soft Tissue Techniques, Exercise and Pilates programs, Dry Needling, and electrical modalities, taping, ice, heat, TENS, shockwave therapy and other therapies.

I understand that; discomfort may occur following treatment.

It is my responsibility to contact the clinic should I experience any unusual symptoms.

That if at any time I am not comfortable with, and/or do not understand the purpose of any treatment procedure I will ask the physiotherapist for further explanation/information.

I intend this consent form to cover the entire course of treatment for my present condition(s), and for any other future condition(s) for which I seek treatment. I understand that I can withdraw my consent at any time. I agree to indemnify the Provider of this service and its employees, agents and representatives from claims made against them in the event that I react to the treatment provided. I have read this form in full and agree to all consent regarding physiotherapy evaluation and treatment.

We value your time and appreciate helping you with your Health care needs. Your appointment is important. As missed appointments may inconvenience other patients, Failure to attend a scheduled appointment or cancellation within 24 hrs of an appointment will result in a charge of a normal consultation fee. We hope that this does not inconvenience anyone too much and should ensure in future that you have the best opportunity of having your needs met in an appropriate time frame.

Print Full Name:_____ **Sign Here**(or Legal Guardian): _____

Date: / / 20

In our digital form, Entering your name in the box above and returning the forms to us acknowledges that you have read the form and consent to assessment and treatment.