# ***S*TRIVE *P*hysiotherapy**

MR / MRS / MS / MISS / MAST/ Dr

SURNAME _____

GIVEN NAMES _____

PREFERRED NAME _____ SEX _____

DATE OF BIRTH _____OCCUPATION _____

STREET ADDRESS _____

SUBURB _____ POSTCODE _____

PHONE (HOME) _____ PHONE (WORK) _____

MOBILE PHONE _____

EMAIL ADDRESS_____

MEDICARE NO. _____EXPIRY _____PATIENT NO._____

PENSION CARD NO. _____EXPIRY _____

VETERAN'S AFFAIRS NO. _____EXPIRY _____

PRIVATE HEALTH FUND _____EXPIRY _____

ARE YOU: ABORIGINAL OR
TORRES STRAIT ISLANDER OR
BOTH OR
NEITHER ?
(please circle which ever applies)

NATIONALITY / COUNTRY OF BIRTH Australia ☐ Other ☐ _____

NEXT OF KIN NAME:_____ RELATIONSHIP _____

PHONE:_____

PERSON TO CONTACT IN CASE OF EMERGENCY SAME AS NEXT OF KIN ☐

NAME:_____ RELATIONSHIP _____

PHONE:_____

1. This surgery operates a computerized reminder system for follow-up health care.
Please tick here if you do not consent to entered onto this system ☐

2. We offer an SMS service to confirm your appointment.
Please tick here if you do not consent to be contacted by SMS ☐

3. From time to time we would like to send you information via email that may be of interest to your health care needs.
Please tick here if you do not consent to be contacted by email ☐

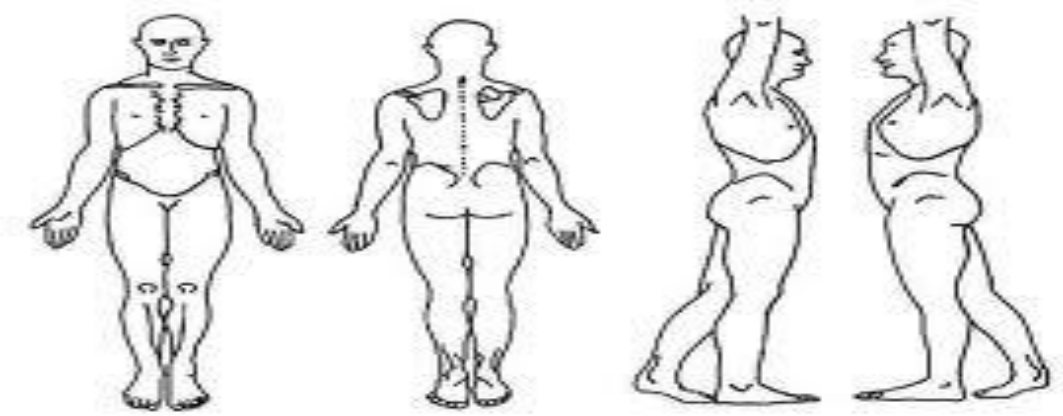
How did you find out about this practice?

☐ Internet Search ☐ Brochure/ Flyer ☐ Lecture/ Course ☐ Yellow Pages /Yellow Pages Online

☐ Gym Member ☐ Poster/ Advert ☐ Directory Assist ☐ Friend Referral: _____

☐ Magazine ☐ Our Website ☐ From My Doctor ☐ Other:_____

Indicate below which part of the body your injury is located:



What is your major complaint? _____

How long have you had this problem? _____

Have you had a similar problem in the past? _____

Have you seen another physiotherapist before? YES ☐ NO ☐

If YES was there anything you were not happy about? _____

What aspects were you happy with? _____

What two things would you like to achieve by the end of your session today

_____

_____

**If you are experiencing pain, please tick the words that best describe your pain:**

Constant ☐ Comes and goes ☐ Intensity varies ☐ Intensity doesn't change ☐

Sharp ☐ Shooting ☐ Achy ☐ Travels ☐ Radiates ☐

**Do you get?**

Pins and Needles ☐ Tingling ☐ Numbness ☐ Weakness ☐

**Since the problem started it is:**

About the same ☐ Getting better ☐ Getting worse ☐

**What makes your pain worse?**

Sitting ☐ Standing ☐ Walking ☐ Other ☐ _____

**Your pain interferes with:**

Work ☐ Sleep ☐ Hobbies ☐ Leisure ☐

**What type of work do you do?** _____

Other health professionals seen for this problem (please list):

Medical doctor: _____

Specialist: _____

Other: _____

Do you have or have you ever had?: (please tick)

| | | |
|---|---|---|
| ☐ High blood pressure | ☐ Cancer | ☐ Spinal fracture |
| ☐ Heart attack | ☐ Osteoporosis | ☐ Spinal surgery |
| ☐ Heart problems | ☐ Rheumatoid arthritis | ☐ Dislocations |
| ☐ Strokes | ☐ Ankylosing spondylitis | ☐ Ligament injuries |
| ☐ Diabetes | ☐ Psoriatic arthritis | ☐ Cartilage injuries |
| ☐ A pacemaker | ☐ Reiter's arthritis | ☐ Osteoarthritis |
| ☐ An aneurysm | ☐ Spinal trauma | ☐ Dizziness |

Are you pregnant? YES ☐ NO ☐

# INFORMED CONSENT FORM

This is NOT a waiver form. It is part of our "duty of care" to you that all physicians, physiotherapists and other allied health practitioners inform you of any material (pertinent) risk associated with professional treatment techniques.

Some therapy techniques such as therapeutic massage, joint manipulations, traction or mobilisations have a very slight risk of causing injury. A remote possibility of injury to structures such as but not limited to; nerves, muscles, ligaments, disc or arteries exist. Electro-physical agents such as ultrasound or interferential therapy have been linked to minor burns and abnormal skin reactions. Acupuncture and the above listed techniques can occasionally cause temporary local swelling, bruising or transitory increases in the level or distribution of pain or other symptoms. Allergic skin reactions to massage oils, strapping tapes, acupuncture needles or topical applications are a possibility.

Following the verbal explanation of my examination results and the explanation of the therapeutic techniques the therapist thinks suit my present condition, I will be asked to give my consent to treatment. I have the right to decline treatment that the therapist offers me at any time. I have the right to a second opinion at any time. I give permission to the therapist to exchange information with my doctor and other medical specialists when necessary. I understand that this information will be confidential.

## NON-ATTENDANCE

Due to the fact that we provide one-on-one hands-on consultations and set aside time for you please give at least 24 hours notice if you are unable to keep an appointment. Reminder calls are available upon request. Missed appointments will attract a non-attendance fee of a minimum $25.00. Thank you for your courtesy in this matter, we look forward to being of assistance and hope that your experience here is a positive one.
**I have read this form, understand the information it contains and give my consent to treatment.**

**Signed_____NAME:_____**

**DATE_____/_____/_____**