

PATIENT INFORMATION SHEET

Title	Surname	Given name	Date of Birth	Sex
				Male/Female
Address		Suburb		Postcode
Telephone Work		Telephone Home		Telephone mobile
E mail			Occupation	

Do you have a Dr/Specialist Referral?	
Doctors Name:	
Address:	
Would you like your GP sent Information regarding your injury and treatment at this clinic?	
Doctors Name:	
What Suburb is their Surgery?	

How did you hear about this clinic? (please tick)			
Doctor Referral	<input type="checkbox"/>	maroubraphysio.com.au	<input type="checkbox"/>
Family /Friend	<input type="checkbox"/>	Health Fund	<input type="checkbox"/>
Walk Past/ Sign	<input type="checkbox"/>	Needaphysio Website	<input type="checkbox"/>
Rehab One	<input type="checkbox"/>	Massage Website	<input type="checkbox"/>
NRMA	<input type="checkbox"/>	Yellow Pages Online	<input type="checkbox"/>
Google	<input type="checkbox"/>	White Pages Online	<input type="checkbox"/>
		Local Pages	<input type="checkbox"/>
		Yellow Pages Book	<input type="checkbox"/>
		White Pages Book	<input type="checkbox"/>
		Advertisement	<input type="checkbox"/>
		Other (Specify)	<input type="checkbox"/>

Do you have Private Health Cover?	Yes/No	Name of Fund:	Are you covered by DVA?	Yes/No
Is this a Workers Comp Claim?	Yes/No	Third Party Claim?	EPC Claim?	Yes/No
Further paperwork will be required for all Workers Comp/ Third Party/DVA Claims.				

What part of the body are we treating today?	
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Would you like any information on the other services we provide at our clinic? (please tick)			
Pilates	<input type="checkbox"/>	Women's Health	<input type="checkbox"/>
		Massage Therapy	<input type="checkbox"/>
		Exercise programmes	<input type="checkbox"/>

Terms and Conditions:

Payment is required at time of Consultation.

I understand that I will be personally responsible for all fees on my account.

A cancellation fee of \$75.00 may apply if I do not give sufficient notice of 24 hours or more.

Full consultation fee may be charged if appointments are missed without notice.

If you are running more than 15minutes late you may have to re-schedule the appointment – please call the clinic.

An administration fee of \$5.50 may be charged for outstanding accounts of 30+days to cover extra postage and account management.

Maroubra Physio will under no circumstances sell, trade or rent any personal information that you supply to us to any third party.

I ACCEPT THE ABOVE TERMS AND AGREE TO ABIDE BY THEM:	
Patient's/Gaurdian's Signature:	DATE:

P.T.O →

Medical Questionnaire

Please take a few minutes to complete this questionnaire before your appointment with the Physiotherapist/Therapist. The health check is for the health professional to find out about your general health and if there any potential implications for your treatment.

The information you provide is confidential and for treatment purposes only.

EXERCISE FREQUENCY

1. How often do you exercise? Never Less than once per week 2 to 4 times per week More than 4 times per week
2. What types of exercise do you do? Walking Running or jogging Gym Pilates/Yoga Sports: _____

MEDICAL CONDITIONS : Please Tick	Yes	No	Details
Are you aware of any Health Problems?			
Do you have a cardiac pacemaker or metal implant?			
Have you had a stroke?			
Do you have heart problems?			
Do you suffer from high/low blood pressure?			
Do you have Diabetes?			
Do you suffer from Epilepsy?			
Do you have asthma or breathing difficulties?			
Do you have or have you had Cancer or a tumour?			
Do you suffer from Arthritis, Rheumatism or other joint problems?			

General Health : Please Tick	Yes	No	Details
Have you lost/gained weight in past 6 months?			
Have you ever been seriously ill or had a major operation?			
Do you have any communicable disease (e.g., hepatitis A, B, C, HIV/AIDS)			
Does any health problem restrict your activities of daily living?			
Are you a current or ex smoker?			Current Cigarettes per day?
Do you consume alcohol?			Alcoholic drinks per day/per week:
Are you currently taking any prescription medication?			Type:
Are you currently taking any non-prescription medication or remedies?			Type:
Are you pregnant or trying?			

Signs & Symptoms: Please Tick	Yes	No	Details
Do you experience chest pains?			
Have you had episodes of shortness of breath?			
Have you had episodes of severe dizziness?			
Do you experience difficulty breathing?			
Do you experience swelling around your ankles?			
Have you ever had heart palpitations?			
Do you regularly get muscle aches in your legs when walking?			
Has your doctor told you that you have a heart murmur?			
Do you know of any reason why you should not engage in physical activity?			

Next of Kin:	Contact Number:
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Thank you for completing this questionnaire The treatment programme we devise for you is based upon current information and evidence based practice as well as the information you have provided.