PATIENT INFORMATION SHEET

Title	Surname	Given name	Date of Birth	Sex
				Male/Female

Address	Suburb	Postcode

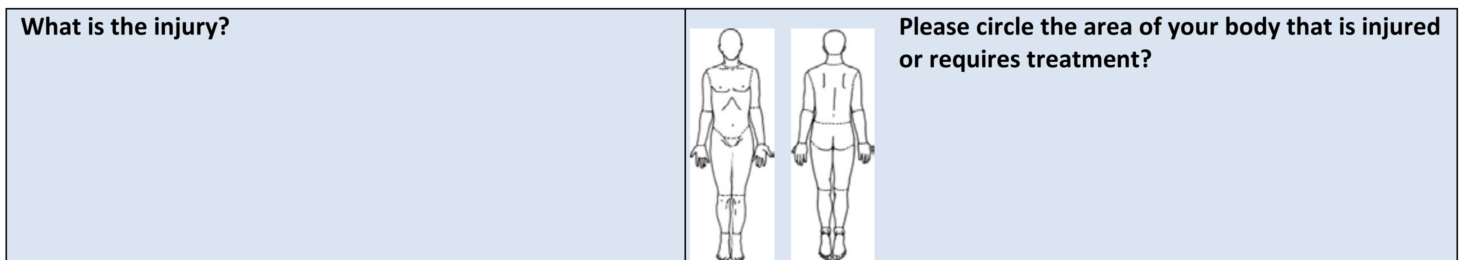
Telephone Work	Telephone Home	Telephone mobile

E mail	Occupation	Pensioner/Student
		YES NO

Do you have a Dr/Specialist Referral? **YES** **NO**	
Doctors Name:	
Address:	
Would you like your GP sent Information regarding your injury and treatment at this clinic? **YES** **NO**	
Doctors Name:	
What Suburb is their Surgery?	

How did you hear about this clinic? (please tick)					
Doctor Referral		Massage Website		Local Pages	
Family /Friend		Health Fund		Yellow Pages	
Walk Past/ Sign		Google		White coat	
NRMA		Anne-Lise – Golf Referrals		Other (Specify)	
maroubraphysio.com.au		Advertisement		Injury Net/UHG	

Do you have **Private Health Cover**? Yes/No Name of Fund:		Are you covered by **Department of Veteran Affairs?** **Gold/White/Blue** **DVA number:**
Medicare Number:	Patient number:	**EPC/Medicare rebate** Claim? Yes / No
Is this a **Workers Compensation or CTP Claim**? Yes / No **Claim #**		**Insurance Company:**
Date of Injury:	**Case manager:**	**Contact number:**
Further paperwork will be required for all Workers Comp/ Third Party/DVA Claims.		

What is the injury?		**Please circle the area of your body that is injured or requires treatment?**

Would you like any information on the other services we provide at our clinic? (please tick)							
Pilates (Mat or equipment/reformer)		**Women's Health** (Incontinence, pregnancy, pelvic floor)		**Massage Therapy**		**Exercise programmes** (Bone Strengthening)	

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:

Please Turn over to complete Medical Questionnaire →

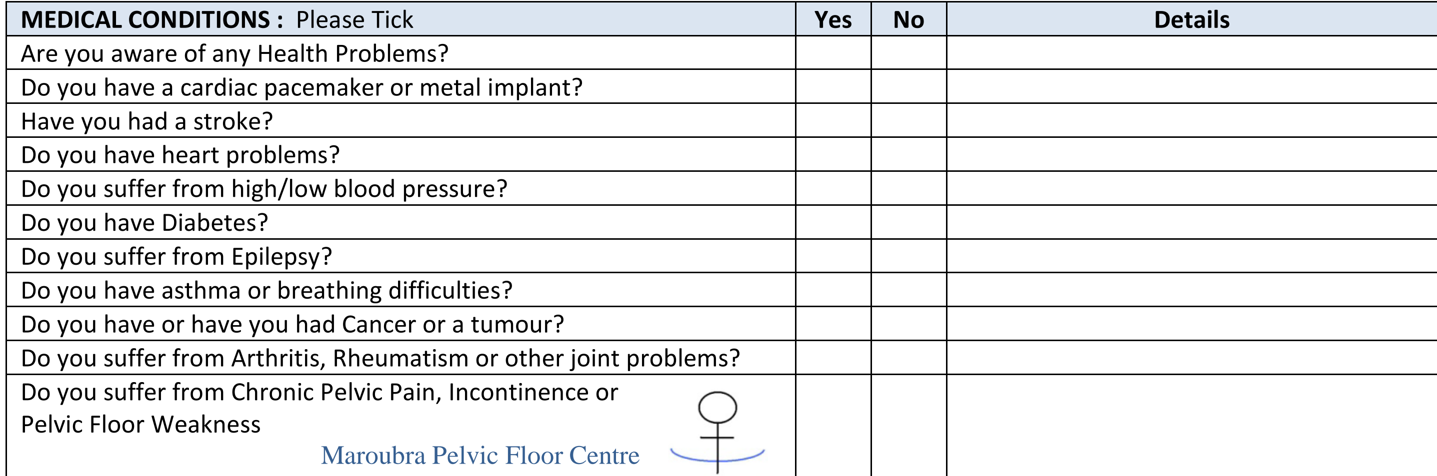
Medical Questionnaire

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?			
Do you suffer from Chronic Pelvic Pain, Incontinence or Pelvic Floor Weakness Maroubra Pelvic Floor Centre			

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:
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.	