LEICHHARDT SPORTS PHYSIOTHERAPY

PATIENT INFORMATION SHEET

Surname: ________________________ **Given Names**: ____________________

Address:____

Suburb:______________________________ **Post Code**:______________

Telephone (w) ____________ **(h)**_____________ **(m)**_______________

Occupation: ___________________________ **Date of Birth**: _______________

Email: ________________________________ **Health Fund**: Yes/No __________

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

What area of the body are we treating today ______________________________

GP details		**Referral Yes/No**
Doctors Name: Address:		
	Do you approve correspondence to your GP regarding your treatment Yes/No	

How did you hear about this clinic? (please tick)					
Doctor Referral		Shopping at MarketPlace		Trinity Grammar	
Specialist Doctors Referral		Leichhardt Aquatic Pool		NRMA	
Family/Friend		Annette Kellerman Pool		Sporting Club	
Internet Search				Other (Specify)	

Please note below if applicable

Is this a Workers Comp Claim Yes/No Pls supply Dr's referral & W/Cover Certificate		Are you covered by Veterans Affairs Yes/No
Third Party Claim Yes/No Pls supply Dr's referral & W/cover Certificate		GP referred EPC – Enhance Primary Care Plan Yes/No
Further paperwork will be required for all Workers Comp/ Third Party/DVA Claims and EPC Care Plans.		

Would you like any information on the other services we provide at our clinic? (please tick)							
Pilates		Massage Therapy		Hydrotherapy		Exercise programmes	

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 $40.00 applies if I do not give 24hrs notice of cancellation.
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 will be charged for outstanding accounts of 30+days.

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

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 are any potential implications for your treatment.
The information you provide is confidential and for treatment purposes only.

Name:

1. How often do you exercise ☐ Never ☐ Less than once a 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**	**Detail**
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 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 the past 6 months			
Have you ever been seriously ill or had a major operation			
Do you have any communicable diseases e.g. Hepatitis A,B,C, HIV			
Do you have any health problems that restrict your activities or day			
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 to conceive			

SIGNS & SYMPTOMS: Please Tick	**Yes**	**No**	**Details**
Do you experience chest pain			
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 palpitation			
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			

Thank you for completing this questionnaire. The treatment programme we devise for you is based upon the current information supplied and evidence based practice as well as the information you have provided.

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