Physiotherapy Client Information

Name: _____

Phone: m: _____ h: _____ w: _____

Emergency Contact: name: _____ ph: _____

Email: _____

DOB: _____ Health Fund: _____ Best Contact: m/h/w/email

Occupation: _____

Sport/Recreation: _____

How you found me: Referral word of mouth Internet search Walk by Other

_____

Usual GP: Name: _____

Address: _____

Phone: _____

Permission to communicate w health professionals: Yes No Please discuss first

Main reason(s) for appointment: _____

Would you like to receive a Quarterly e-newsletter? Yes No

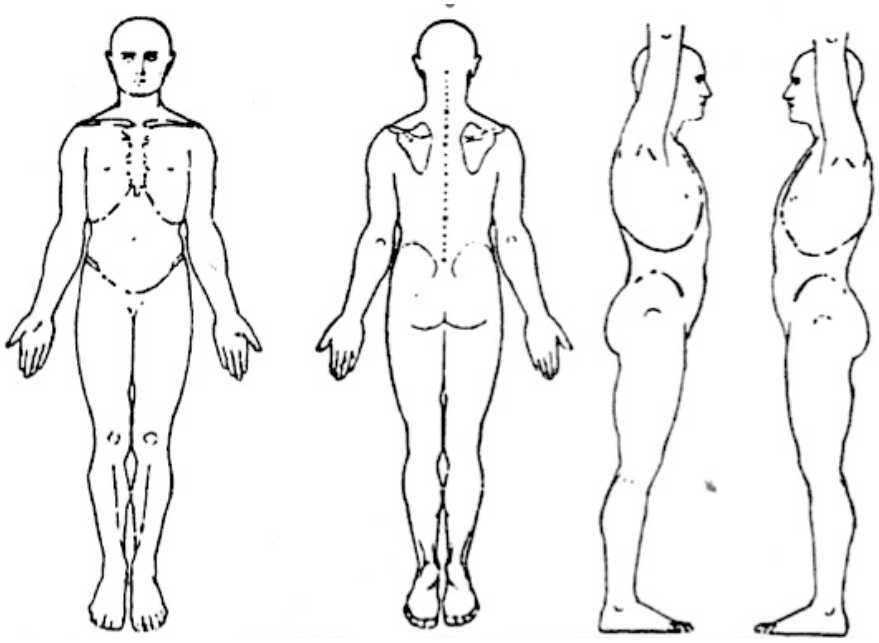
Address/Suburb: _____

Postal (if different): _____

Are you being referred for treatment through: WorkCover/Motor Vehicle Insurance/DVA

...claim number Contact person/ph:

As a courtesy and to avoid cancellation fees please give 24-48 hours notice to change an appointment
<24 hrs notice 50% and non-attendance 100% fee apply



General Health Questionnaire

Y/N **Cardio-vascular:** including high or low blood pressure, high cholesterol, heart attack, aneurysm, thrombosis,sclerosis, embolus, reduced clotting, peripheral vascular disease or other

Y/N **Respiratory:** including asthma, sinus difficulties, bronchitis, pneumonia, bronchiectasis, COPD, other

Y/N **Digestive:** including gastritis, indigestion, reflux, GORD, hiatus hernia, ulcers, gall stones, coeliac, IBS, colitis, constipation, other

Y/N **Central Nervous System:** including concussion, head injury, epilepsy, other

Y/N **Genito-Urinary:** including prolapse, bladder problems, UTI/cystitis, kidney stones/infections, other

Y/N **Immune: incl chronic inflammation/infections**

Y/N **Cancer/Malignancy:**

Y/N **Infectious conditions:**

Y/N **Inflammatory Conditions:** including Lupus, Rheumatoid arthritis

Y/N **Endocrine:** including thyroid, adrenals, diabetes, osteoporosis/osteopaenia, mesntrual cycle problems, other

Y/N **Cigarette Smoking**:

Y/N **Connective Tissue Disorders:**

Please complete as applicable:

Medication/supplements:

Usual Fluid Intake:

Surgery (recent & past):

Implants/Orthotics:

Current pregnancy?

Pain at night:

Recent weight changes:

Oral Cortico-Steroid Use:

Other health practitioners:

Anything else important:

Signature: **Date:**