

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

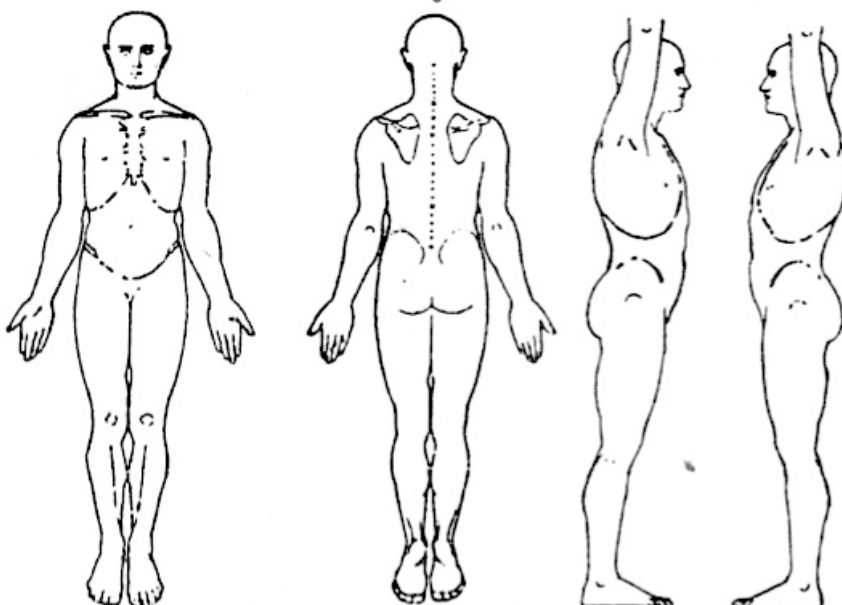
Address/Suburb:

Postal (if different):

Are you being referred for treatment through:

WorkCover Motor Vehicle Insurance DVA

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



PTO 

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

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

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

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

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

Y N **Musculoskeletal System:**

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, menstrual cycle problems, other

Y N **Cigarette Smoking:**

Y N **Connective Tissue Disorders:**

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:

This page is optional - complete if you think it relevant to you, or if you have been asked to fill it out

The "Patient Specific Functional Scale" (PSFS)

- * *The Patient Specific Functional Scale* can be useful to quantify activity limitation and measure functional outcomes.
- * Identify 3 or more activities that at the moment you are unable to do or having difficulty doing (due to the problem for which you have made this appointment).
- * Rate each activity on a scale from 0-10 where 0 is unable to perform the activity at all, and 10 is able to perform the activity at the same level as before said problem started.

Patient-specific activity scoring scheme (Point to one number):

0	1	2	3	4	5	6	7	8	9	10
Unable to perform activity					Able to perform activity at the same level as before injury or problem					

Activity	Date and scores columns >>>>				
1.					
2.					
3.					
4.					
5.					
Additional					
Additional					

Pain Numeric Rating Scale

The Pain Numeric Rating Scale can be used to communicate pain levels, and to help monitor changes with treatment. It is a scale from 0-10 where 0 is no pain at all and 10 is the worst pain imaginable:

0	1	2	3	4	5	6	7	8	9	10
No Pain					Worst Pain Imaginable					

On a scale of 0-10, how would you rate your...	Date and scores columns >>>>				
... level of pain right now?					
... usual level of pain during the past week?					
... lowest level of pain during the past week?					
... highest level of pain during the past week?					