oh! physio
MUSCULOSKELETAL PHYSIOTHERAPY

Patient details

First name: _____ Last name: _____

DOB: _____ Home phone: _____

Mobile: _____ Email: _____

Address: _____

Occupation: _____

GP and contact details: _____

Emergency contact:
Name: _____
Contact number: _____
Relationship: _____

Health / Medical Details - For your safety and protection, and for our information.

Have you previously received physiotherapy for this condition?	Y/N
Have you had surgery in the last year?	Y/N
Do you wear a hearing aid or pacemaker?	Y/N
Do you have any artificial implants – e.g., metal screws / joint replacements?	Y/N
Do you have AIDS / HIV / Hepatitis / MRSA?	Y/N
Do you have a personal or family history of cancer?	Y/N
Are you pregnant?	Y/N
Are you on long term medication?	Y/N
Do you have any allergies to tape or medications?	Y/N
Have you been diagnosed with high blood pressure?	Y/N

Do you have any serious/chronic health problems? e.g. Epilepsy / diabetes / asthma / heart or respiratory problems / blood clotting disorders / osteoporosis / arthritis / rheumatoid arthritis / ankylosing spondylitis

Have you had any recent/new or unusual symptoms (circle if yes)

Sofie Boswell
BHsPhysiotherapy

Sports injuries
Post operative rehabilitation
Low back & neck pain
Overuse & repetitive stress injuries

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MUSCULOSKELETAL PHYSIOTHERAPY

- Weight loss/gain
- Vomiting
- Dizziness Fatigue
- Fever
- Chills
- Speaking/Swallowing
- Double vision
- Headaches
- Fainting
- Sweats
- Numbness/tingling
- Pins & Needles
- Nausea
- Weakness

Consent to treatment

- I hereby give my consent for physiotherapy treatment and a full verbal explanation will be given at the time of treatment.
- I have the right to decline part or all of the treatment offered to me at any time. I can ask for a second opinion or change my treatment provider in accordance with Section 7 of the Health and Disability Service Consumer Rights 1996.
- I will pay for any associated treatment costs (splints, braces, rehab equipment etc.) and to pay for any treatments declined by ACC or my private insurer.
- All ACC visits are a $10 surcharge fee and must be paid on completion of treatment.
- Fees for private visits are to be paid on completion of treatment.
- Cancellation of appointment must be made 3 hours prior or a $10 fee will incur.
- *In accordance with the Privacy Act, all information recorded in your health records will be kept confidential. Your records will only be accessed by the Physiotherapist providing your care and those whom process your ACC claims.*
- *Under the Privacy Act, you have the right to access to, and the correction of, your personal information held by this practice. No information will be released without your consent.*

Signature: _____ Date: _____

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