

PHYSIOWAYS REGISTRATION

Please Complete ALL Questions:

TITLE: Mr / Mrs / Miss / Ms / Other		Surname:	
First Name:		Date Of Birth:	Age:
Home Address:		Occupation:	
		Employer:	
Post code:		Is your work mainly: Sitting / Manual / Mixed / Driving / Other	
Home Phone No:	Mobile No:	Work No:	
E-mail: (please include this if you wish to receive our newsletter electronically and any other news and offers by e-mail)			
GP Name:		GP Address:	
Contact person and number (in case of emergency):			
Where did you hear about us? Please circle appropriate details Yellow pages – Derby – Physiotherapists / Sports Injuries / Occupational Health Yellow Pages – Chesterfield & Mansfield – Physiotherapists / Sports Injuries / Occupational Health Doctor - please give name:..... Advertisement – please state where and when..... Poster / picked up Business Card – please state where and when..... Recommended – please state name:..... Other – please state.....			
How do you intend to pay for your consultations? (We regret we are not able to accept credit card payment at this time) <input type="checkbox"/> Cash / Cheque <input type="checkbox"/> Debit card No..... <input type="checkbox"/> Employer to pay : NAME of Employer:..... <input type="checkbox"/> Private Health Insurance: <i>Please complete box below</i> <input type="checkbox"/> Accident Insurance: <i>Please complete box below</i>			
Insurance Company Details:			
COMPANY NAME:			
Policy No:		Excess:	
Authorisation No:			
Employer Name (for Corporate Schemes)			
<input type="checkbox"/> <i>I confirm that the information given above is correct at the date shown below.</i> <input type="checkbox"/> <i>I understand that it is my responsibility to inform my therapist of any change in my contact details.</i> <i>I agree to pay for all services, including any costs not covered by my insurance company.</i>			
Signature:		Printed:	Date:

What problem do you require treatment for?
How long have you had this problem?
What do you believe caused this problem? Please circle Work injury or accident / Sports injury / Road Accident / Other accident / Unknown or Gradual Onset
Please give us some background to the problem: If you have pain where is it? If you have pins and needles where are they? If you have numbness where is it? If you have weakness where is it? If you have any other symptoms not listed above please describe them and where they are here. Is there any pattern to your pain / symptoms over 24 hours? Yes / No If Yes , please describe:
Have you had treatment for this condition before? YES / NO If YES please give a brief summary of who provided the treatment, type of treatment and whether it was helpful:

Client Name:

PAST MEDICAL HISTORY:
Do you have or have you had any of the following medical conditions? (please tick) <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Asthma <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood pressure <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Cancer <input type="checkbox"/> Unexplained weight loss <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Blood disorders (HIV, Hepatitis) <input type="checkbox"/> Addictions <input type="checkbox"/> Other (inc Pregnancy)
Do you have any family history of any of these conditions? YES / NO If YES, please give details:
Do you take any prescribed medications? YES / NO If YES please state name and dose
Have you had any serious accidents, illnesses or operations? YES / NO Please give details
It is our policy to write to your GP on completion of your course of treatment. <input type="checkbox"/> Please tick the box to indicate your consent for us to do this.
CONSENT: In order for us to assess and treat your condition, you must give consent for us to examine you and then to treat you with appropriate techniques, some of which will involve the therapist touching you. In most cases you will be asked to undress to your underwear. If at anytime during your course of treatment you do not wish to continue with a particular type of treatment you must inform your therapist immediately. The therapist will inform you of any risks associated with the proposed treatments before beginning. If you feel they have not been adequately explained please ask for further information. I have read the consent notice above and understand that by attending the clinic my consent to appropriate examination and treatment is implied. It is within my rights and it is my responsibility to withdraw consent for any treatment that I do not feel fully informed about or do not wish to continue with. I accept that no cure is guaranteed and that my condition is my responsibility. Signature: Name Printed: Date:

Client Name:

PHYSIOWAYS REGISTRATION – Page 4

Home life: Please tell us what kind of tasks you do in every day life (e.g. dressing, washing, housework, childcare) and whether any of these are difficult due to your current condition.

Hobbies: Please tell us about any hobbies that you have, including sports, gardening, crafts and the main postures required for them (e.g. tapestry – sitting leaning forwards for up to 1 hour). For sport please tell us what level you perform at, number of times per week etc. (e.g. run marathons – train 3 x week, 7 miles each)

Family: Do you have family at home / locally? Who? Are you the main carer for anyone?

Worries: Is there anything in particular that is worrying you about your condition? Please say what here:

What activities are you unable to do specifically because of your condition?

What do expect your treatment to involve?

How quickly do you expect your condition to improve?

How much effort / work do you expect to do yourself to improve your condition?

Client Name:

PHYSIOWAYS REGISTRATION – Page 5

Please tell us what you feel your main problems are as a result of your current condition, in order of priority to you: 1. 2. 3. 4.	
What goals or targets do you have that you hope physiotherapy will be able to help you reach? In order of priority: 1. 2. 3. 4.	
1	What do you understand is the cause of your symptoms? (E.g I have damaged a disc) Is this because someone has told you this, or is it what you believe has happened?
2	What are you expecting will help you to get better?
3	If you work, have you had time off work in the past with your symptoms? If you do not work – please mark as N/A
4	How does your employer respond to your condition? If you do not work – please mark as N/A
5	How do your co-workers / friends respond to your condition?
6	How are your family responding to your condition?
7	What do you currently do to help you cope with your condition?
8	Do you think you will be able to return to your usual level of activity or work? When?

Thank you for completing the forms.
Please bring them with you to your assessment.

Client Name: