BAY ACTIVE PHYSIO

TITLE: Select SURNAME: GIVEN NAME

ADDRESS SUBURB POSTCODE

DOB : Email

PHONE :(H) (W) (M)

GP : Specialist/Surgeon:

How did you find out about us?

◯ Friend (name) ◯ Doctor ◯ Web ◯ Yellow pages ◉ other

Is your visit as a result of a Work Cover Claim or Motor Vehicle Accident?

◯ Yes ◉ No

1. Main purpose of visit?
2. Do you play any sports?
3. What is your occupation?
4. Have you had X-rays, CT, MRI, Ultrasounds? ◯ Yes ◉ No
5. Have you had any other investigations?eg blood test ◯ Yes ◉ No
6. Have you had previous physio/osteo/chiro ◯ Yes ◉ No

Your **Personal Health Information and your Health Record** may be collected, used and disclosed for the following reasons:
For communicating with other treating medical professionals, for follow-up/reminder calls, for discussion with third party insurers, accounting/medicare/health insurance procedures, for use by all physiotherapists in this practice when consulting with you and for legal disclosure as required by a court of law.
If you have any concerns or wish to restrict access to your information please discuss these with your physiotherapist or receptionist. This practice adheres to National Privacy Principles (www.privacy.gov.au).

As a Physiotherapy practice providing comprehensive care, we focus on your ability to be healthy. Our goals are: firstly, to address the issues that brought you to this practice; secondly, to treat the cause of your condition (not just treat the symptoms or place a temporary patch over your condition); and thirdly, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of your health.

CONFIDENTIAL PATIENT CASE HISTORY

What is your major problem?

How long have you had this problem?

Have you had this or a similar problem in the past?

If you are experiencing pain, please tick the words that best describe your pain:

☐ Constant	☐ Intensity varies	☐ Sharp	☐ Pain is local
☐ Comes and goes	☐ Intensity doesn't vary	☐ Shooting	☐ Pain Radiate/Travels
☐ Deep	☐ Annoying	☐ Achy	☐ Burning

Do you get?

☐ Pins and needles ☐ Tingling ☐ Numbness ☐ Weakness

Since the problem started is it:

☐ About the same ☐ Getting better ☐ Getting worse ☐ Variable

What makes it worse?

☐ Sitting ☐ Getting up ☐ Walking ☐ Other

Interferes with:

☐ Work ☐ Sleep ☐ Hobbies ☐ Leisure

What activities does your work involve and what percentage?
(eg, sitting 20%, lifting10%, standing40%)

Other health professionals seen for this problem (please list):
Medical Doctor: SpecialistDoctor/Surgeon:
Health Care practitioner: Physio/Chiro/Osteo:
Other :

List any medications you are taking:

Have you ever taken oral cortisone or prednisone (including asthma medications such as pulmicort, symbicort, flixotide & seretide)? ◯ **Yes** ◉ **No**
Are you pregnant? ◯ **Yes** ◉ **No**
Do you have or have you ever had?: (please tick)

☐ High blood pressure	☐ Cancer	☐ Spinal fracture
☐ Heart attack	☐ Osteoporosis	☐ Spinal surgery
☐ Heart problems	☐ Rheumatoid arthritis	☐ Dislocations
☐ Strokes	☐ Ankylosing spondylitis	☐ Ligament injuries
☐ Diabetes	☐ Psoriatic arthritis	☐ Cartilage injuries
☐ A pacemaker	☐ Reiter's arthritis	☐ Osteoarthritis
☐ An aneurysm	☐ Spinal trauma	☐ Dizziness