



New Patient Registration

Title: Mr Mrs Miss Ms Male Female

Surname: _____ First Name: _____

Date of Birth: _____

Street Address: _____

Suburb: _____ Post Code: _____

Telephone: Home: _____ Work: _____ Mobile: _____

Email: _____

Your Dr's Name: _____

Doctor's Address: _____

Do you have a pension card? No Yes

Emergency Contact: _____ Phone: _____

How did you find out about this practice? Online Local Directories Our Signage Doctor Word of Mouth

Other (Please Mention): _____

Do you have allergies: _____

Do you have Private Health Insurance? No Yes, name: _____

What is the reason for seeking our services today? _____

What are your short term goals to achieve from physiotherapy, what time frame? _____

Do you also have long term health goals? _____

Occupation: _____

How physically active is your job: _____

Hobbies, sports, physical activity: _____

Do you normally exercise? Y / N If so, what do you do? _____





The following information will ensure we optimise your outcome and deliver physiotherapy excellence. As a physiotherapy practice providing comprehensive care, our goals are:

- 1 - To address the issues that brought you to this practice,
- 2 - To treat the cause of your condition (not just treat the symptoms or find a temporary solution).
- 3 - To offer you the opportunity of improved health potential and wellness services in the future .

What is your Height? _____ What is your Weight? _____

Draw on the sketch below, the area where you feel your problem to be.

	Back Body			
	L	R		
<input type="checkbox"/> Neck		<input type="checkbox"/> Neck	<input type="checkbox"/> Neck	<input type="checkbox"/> Neck
<input type="checkbox"/> Shoulder		<input type="checkbox"/> Shoulder	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Upper Back		<input type="checkbox"/> Arm	<input type="checkbox"/> Arm	<input type="checkbox"/> Arm
<input type="checkbox"/> Arm		<input type="checkbox"/> Elbow	<input type="checkbox"/> Elbow	<input type="checkbox"/> Elbow
<input type="checkbox"/> Elbow		<input type="checkbox"/> Lower Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Wrist
<input type="checkbox"/> Wrist		<input type="checkbox"/> Wrist	<input type="checkbox"/> Hip	<input type="checkbox"/> Hip
<input type="checkbox"/> Hip		<input type="checkbox"/> Hip	<input type="checkbox"/> Upper Thigh	<input type="checkbox"/> Upper Thigh
<input type="checkbox"/> Upper Thigh		<input type="checkbox"/> Upper Thigh	<input type="checkbox"/> Knee	<input type="checkbox"/> Knee
<input type="checkbox"/> Knee		<input type="checkbox"/> Knee	<input type="checkbox"/> Calf	<input type="checkbox"/> Calf
<input type="checkbox"/> Calf		<input type="checkbox"/> Calf	<input type="checkbox"/> Ankle	<input type="checkbox"/> Ankle
<input type="checkbox"/> Ankle		<input type="checkbox"/> Ankle	<input type="checkbox"/> Foot	<input type="checkbox"/> Foot
<input type="checkbox"/> Foot		<input type="checkbox"/> Foot		

What do you think started this 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 Travels Achy Comes and Goes Radiates Intensity Doesn't Vary

Do you get: Pins and Needles Tingling Numbness Weakness

Since the problem started, is it: About the Same Getting Better Getting Worse

Which activities make your pain worse? _____

Which activities ease your pain? _____

Does this problem disturb your sleep? _____

What is it like when you wake up in the morning? _____

Does the pain change during the day? Y / N If so, how? _____

How bad is the pain on a scale of 0 - No Pain to 10 - Worst Pain Imaginable

At Best ____ /10 At Worst ____ /10

Do you generally feel healthy? Please list any problems with your general health: _____

Previous conditions or operations: _____

Other health professionals seen for this problem (please list): Medical Doctor Specialist Surgeon Chiropractor

Massage Therapist Bowen Therapist Other: _____

Name of other health professional: _____

List medications you are taking: _____

- Do you have or have ever had? High Blood Pressure Bladder or Bowel Difficulty Heart Problems Strokes
- Diabetes A Pacemaker Aneurysm Osteoporosis Cancer
- Rheumatoid Arthritis Ankylosing Spondylitis Psoriatic Arthritis Reiter's Arthritis Pregnant
- Spinal Trauma Spinal Fracture Spinal Surgery Cartilage Injuries
- Dizziness Dislocations Ligament Injuries Implants
- Osteoarthritis Unexpected Weight-Loss Joint Replacements Epilepsy or Seizures
- Taken Steroids/Oral cortisone/prednisolone Recent Nausea/Feeling unwell

Details: _____



PHYSIO MELBOURNE

YOU'RE IN GOOD HANDS

Physio Melbourne Clinic - Policy

Our goal is to deliver an exceptionally friendly and professional service providing you with the best in physiotherapy care.

RECOVERY

Remember that healing and recovery takes time and not everyone heals/recovers at the same rate. If at any time during your care, you do not feel that you are responding as well as expected, please discuss this with your physio. We want you to get the most from your care at Physio Melbourne Clinic.

REFERRALS

The greatest compliment we can receive is the referral of a friend or family member. We look forward to assisting you and trust that your experience here is a positive one.

APPOINTMENT SCHEDULING

Your physiotherapist will outline a recommended action plan as the best plan for your injury. You will achieve the maximum results when you keep your recommended action plan to this schedule. To receive the most out of your care, and to save time, we ask that you schedule your appointments when receiving your plan.

MISSED APPOINTMENTS

24 hours notice will allow rescheduling to other clients in need. Failure to give 24 hours notice may require you to prepay for your appointment. Prepayment is non-refundable and if forfeited this fee is not rebatable. Missed appointments will set you back in your recovery.

X-RAYS AND SCANS

Our team can obtain your recent Radiology scan results. Please inform our receptionists if you have had any imaging completed for body areas relevant to your appointment today. Your signature below gives consent for PMC to obtain your scan results.

CORRESPONDENCE

Our physiotherapists will contact your nominated Doctor to inform them of your progress. At Physio Melbourne Clinic we believe in building a team of health care professionals to best achieve your health goals. Your signature below confirms that you give permission to the therapist to exchange information with your Doctor, Allied Health Practitioners, Medical Specialists, Lawyers, and third party (insurance/ Workcover) Case Managers, and allow access to My Health Record when necessary.

This information will be confidential, please refer to Privacy policy (<https://www.physiomelbourne.com.au/privacy-policy>) for details

Treatment Terms and Consent

Physiotherapy treatment is an effective and safe form of treatment however like any treatment there are benefits and risks.

Physiotherapists in this practice will discuss your condition and options for treatment with you so that you are appropriately informed and can make decisions relating to treatment. You may choose to consent or refuse any form of treatment for any reason including religious or personal grounds.

Typical physiotherapy carries a remote possibility of injury to structures such as but not limited to; nerves, bones, muscles, ligaments, discs or arteries. Physiotherapy can occasionally cause local swelling, bruising or transient increases in pain or other symptoms. Electro- physical agents such as ultrasound or inferential therapy have been linked to minor burns and abnormal skin reactions. Allergic skin reactions to creams, tape, or needles are a possibility.

You will be asked to expose the injured body part for assessment and treatment. Please inform your physiotherapist if you feel uncomfortable at any time, as alternative methods maybe available. Your physiotherapist may ask personal questions relating to your injury and how your injury impacts on your 'activities of daily living'. The more information you provide, the more likely it is that the physiotherapist can provide effective treatment. If you feel uncomfortable with a particular question please let the Physiotherapist know. You have the right to a second opinion at any time. The large array of skills in our team allows this to occur easily. Please contact your physiotherapist immediately if you experience adverse reactions. It is important to attend follow-up appointments as arranged by your physiotherapist to allow completion of your course of planned treatment.

Name: _____ Signed: _____ Date: _____

The above must be at least 18 years of age, otherwise consent from a custodial parent is required to treat a minor.