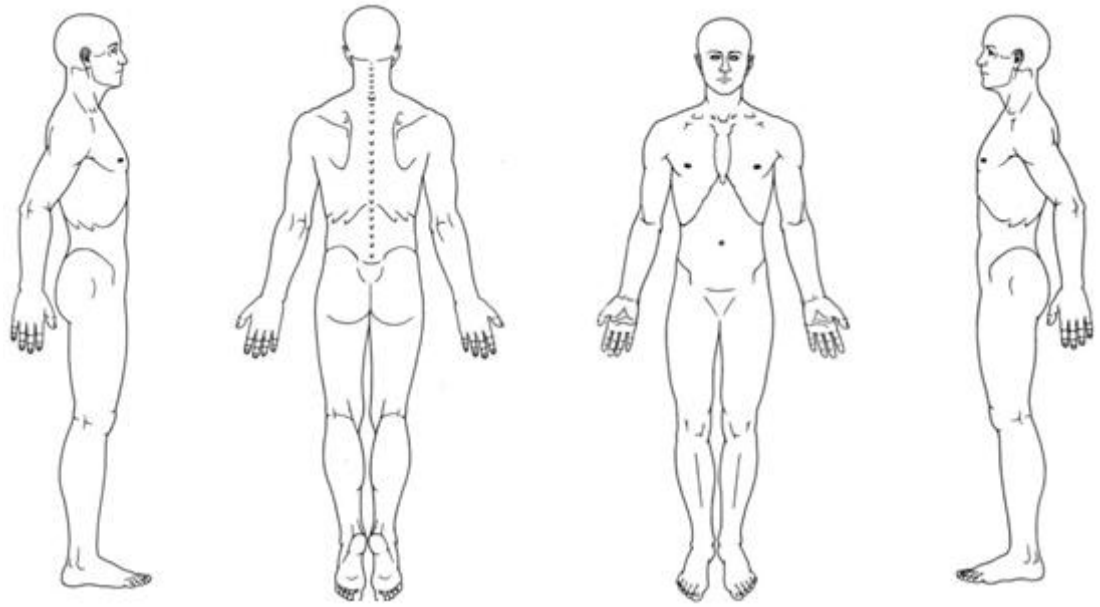
connecthealthcare

physiotherapy new client form

general information

Full Name: _____ Date of Birth: _____ / _____ / _____



please indicate on the diagram above the location of your pain / discomfort

What brings you in today:_____

When did this begin: _____

What caused this problem: _____

Has this occurred before? Yes / No If yes, how long ago? _____

Have you received any other treatment for this issue? _____

Do you or have you previously smoked? Yes / No *If yes, amount per day:* _____

Do you consume alcohol? Yes / No *If yes, amount (glasses) per day:*_____ *or per week:* _____

Do you take any recreational or non-prescription drugs? Yes / No

Are you physically active? Yes / No *If yes, hours per day:*_____ *or per week:*_____

How many hours of sleep do you get per night? _____

Have you experienced any of the following in the past month or since the onset of your main presenting health problem?

	YES	NO
Nausea or vomiting		
Fever or rashes		
Pins and needles or numbness		
Joint swelling or unusual lumps on body		
Dizziness, vertigo or light-headedness		
Fainting or loss of consciousness		
Issues with vision		
Difficulty in breathing		
Chest pain or discomfort		
Pain or blood loss during urination or bowel movements		

Have you ever been diagnosed with any of the following health problems?

	YES	NO
High blood pressure		
Heart condition (including heart attack)		
Stroke, TIA or aneurysms		
Respiratory conditions (e.g. asthma, COPD)		
Thyroid problems		
Cancer		
Diabetes or abnormal blood sugar levels		
Allergies or other immune related conditions		
Other vascular or systematic conditions		
Bone or joint diseases (osteoporosis, arthritis etc.)		

Do you have any family history of:

	YES	NO
Blood disorders		
Heart conditions		
Diabetes		
Stroke		
Autoimmune diseases		
Epilepsy		
Genetic disorders		
Cancer		
Nervous system disease		
Muscle, bone or joint conditions		

Do you currently suffer from any of the following?

	YES	NO
Unexplained fevers		
Night sweats		
Abnormal bleeding		
Unexplained weight loss or gain		
Pain causing you to wake at night		
Sudden onset of an intense headache you have not had before		
Difficulty with bowel or bladder control		

patient information

Please read the following information carefully before signing.

Risks of care & consent for care

Physiotherapy treatment is generally an effective and safe form of treatment; however, like any treatment there are benefits and risks. Physiotherapists in this clinic 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 to or refuse any form of treatment for any reason including religious or personal grounds. You have the right to a second opinion at any time. Once you have given consent, you may withdraw that consent at any time.

Please read the following:

1. **Questions of a personal nature**
   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 an effective treatment. It is your choice as to what information you choose to provide. If you feel uncomfortable with a particular question or group of questions, please let the physiotherapist know and they will cease.

2. **Physical contact**
   During the examination, assessment and treatment it may be necessary for your physiotherapist to make physical contact. Your physiotherapist will ask your permission before making physical contact with you in any way. Physical contact requires your express consent. You may withdraw that consent at any time at which point, all physical contact will cease immediately. Please inform your physiotherapist if you feel uncomfortable at any time.

3. **Risk related to treatment**
   As with all forms of treatment, there are risks and benefits. Some therapy techniques have a very slight risk of causing injury. A remote possibility of injury to structures such as but not limited to; nerves, bones, muscles, ligaments, discs, skin or arteries exists. Research evidence indicates that skilled cervical (neck) manipulation is safer than taking anti-inflammatory medication. In very rare circumstances (less than 1 in 163,000 to 5.8 million), damage may occur to the vertebral arteries in the neck and the patient may suffer a stroke. There is a small risk that treatment may produce pressure on the nerves going down the arm or leg. Electro-physical agents such as ultrasound or interferential therapy have been linked to minor burns and abnormal skin reactions. Dry needling and the above listed techniques can occasionally cause temporary local swelling, bruising or transitory increases in the levels or distribution of pain or other symptoms. In very rare cases dry needling has been reported as being associated with bodily infections or collapse of a lung (less than 1 in 70 000- 1.27 million). Allergic skin reactions to massage oils, strapping tapes, dry needling needles or topical applications are also a possibility. The physiotherapist will discuss any foreseeable risks with you prior to administering treatment. In some cases, the physiotherapist may ask you to read information related to a particular treatment and they may request that you sign a further consent form. This is to ensure that you fully understand any risks involved. You may withdraw your consent at any time even if you have previously signed a consent form.

4. **Children and minors**
   Consent from a custodial parent is required to treat a minor.

5. **Substituted consent**
   Where a person is incapable of understanding the risks and benefits of treatment, consent may be provided by another person legally authorised to provide such consent. Evidence of legal authorisation is required in such circumstances.

6. **You need to let us know**
   The risk related to some treatments can increase if the physiotherapist is not aware of certain facts. Please inform the physiotherapist if you have:
   - a pacemaker or heart condition
   - suffered from blood clots, thrombosis or stroke
   - suffered from diabetes
   - are currently taking medication

Patient Name: _____ Date: _____

Signed: _____