Initial Appointment Form | Elemental Physiotherapy

Name: _____

Phone: m: _____ h: _____ w: _____

Emergency Contact: name: _____ ph: _____

Email: _____

DOB: _____ Health Fund: _____ Best Contact: ☐ m ☐ h ☐ w ☐ email

Occupation: _____

Sport/Recreation: _____

How you found me: ☐ Referral ☐ word of mouth ☐ Internet search ☐ Walk by ☐ Other

Usual GP: Name: _____

Address: _____

Phone: _____

Permission to communicate w health professionals: ☐ Yes ☐ No ☐ Please discuss first

Main reason(s) for appointment: _____

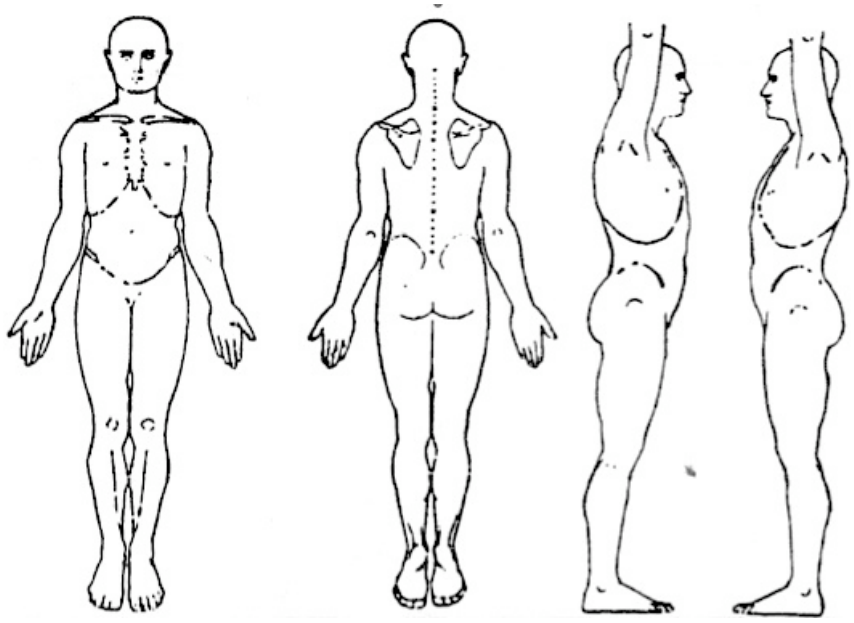
Would you like to receive occasional newsletters/blogs? ☐ Yes ☐ No

Address/Suburb: _____

Postal (if different): _____

Are you being referred for treatment through: ☐ WorkCover ☐ Motor Vehicle Insurance ☐ DVA

As a courtesy and to avoid cancellation fees please give 24-48 hours notice to change an appointment
<24 hrs notice 50% and non-attendance 100% fee apply



PTO —>

General Health Questionnaire

□Y □N **Cardio-vascular:** including high or low blood pressure, high cholesterol, heart attack, aneurysm, thrombosis, sclerosis, embolus, reduced clotting, peripheral vascular disease

□Y □N **Respiratory:** including asthma, sinus difficulties, bronchitis, pneumonia, bronchiectasis, COPD

□Y □N **Digestive:** including gastritis, indigestion, reflux, GORD, hiatus hernia, ulcers, gall stones, coeliac, IBS, colitis, constipation

□Y □N **Genito-Urinary:** including prolapse, bladder problems, UTI/cystitis, kidney stones/infections

□Y □N **Central Nervous System:** including concussion, head injury, epilepsy

□Y □N **Musculoskeletal System:**

□Y □N **Immune: incl chronic inflammation/infections**

□Y □N **Cancer/Malignancy:**

□Y □N **Infectious conditions:**

□Y □N **Inflammatory Conditions:** including Lupus, Rheumatoid arthritis

□Y □N **Endocrine:** including thyroid, adrenals, diabetes, osteoporosis/osteopaenia, mesntrual cycle problems, other

□Y □N **Cigarette Smoking**:

□Y □N **Connective Tissue Disorders:**

Medication/supplements:

Usual Fluid Intake:

Surgery (recent & past):

Implants/Orthotics:

Current pregnancy?

Pain at night:

Recent weight changes:

Oral Cortico-Steroid Use:

Other health practitioners:

Anything else important:

Signature: **Date:**

This page is optional - complete if you think it relevant to you, or if you have been asked to fill it out

The "Patient Specific Functional Scale" (PSFS)

* *The Patient Specific Functional Scale* can be useful to quantify activity limitation and measure functional outcomes.
* **I**dentify 3 or more activities that at the moment you are unable to do or having difficulty doing (due to the problem for which you have made this appointment).
* Rate each activity on a scale from 0-10 where 0 is unable to perform the activity at all, and 10 is able to perform the activity at the same level as before said problem started.

Patient-specific activity scoring scheme (Point to one number):

0 1 2 3 4 5 6 7 8 9 10

Unable to perform activity

Able to perform activity at the same level as before injury or problem

Activity | **Date and scores columns >>>>**					
1.					
2.					
3					
4.					
5.					
Additional					
Additional					

Pain Numeric Rating Scale

The Pain Numeric Rating Scale can be used to communicate pain levels, and to help monitor changes with treatment. It is a scale from 0-10 where 0 is no pain at all and 10 is the worst pain imaginable:

0 1 2 3 4 5 6 7 8 9 10

No Pain

Worst Pain Imaginable