**Please complete the following questionnaire if this is your first visit to the practice or if you have not been to this practice during the previous 6 months.**

Please complete the questionnaire about important background information.

It will remain confidential and ensures a thorough evaluation. If you do not understand a question, we will help you. Thank you kindly.

Name: …………………………………………………………………….…………………………. Age: ……..…...….. Date: ………..……………..….

Reason for seeking physiotherapy treatment, e.g. back pain: …….……………………….……………………………………..……………

……………………………………………………………………………………….………………………Referring Doctor: ……………………………………

Have you been diagnosed with, or had one of the following? Please specify

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **Yes** | **No** | **Medication or treatment**  |
| Allergies |  |  |  |
| Arthritis – rheumatoid or other  |  |  |  |
| Blood Pressure (High/Low) |  |  |  |
| Cancer (what kind) |  |  |  |
| Cardiac problems: pacemaker, angina, etc. |  |  |  |
| Cholesterol |  |  |  |
| Diabetes |  |  |  |
| Dizziness |  |  |  |
| Medication: chronic e.g. steroids, HRT, etc. |  |  |  |
| Medication: current e.g. anti-inflammatory, pain, etc.  |  |  |  |
| Osteoporosis |  |  |  |
| Respiratory Problems: asthma, emphysema, etc. |  |  |  |
| Smoker |  |  |  |
| Unlisted problems |  |  |  |

**Please turn the page over for further information needed**

Have you had investigations for **this current** condition? X-rays, CT scan, MRI, US. Please specify.

|  |
| --- |
|  |

Please list previous surgical procedures or conditions which you have been hospitalised for, and any previous injuries such as fractures and sprains. State the approximate year.

|  |  |
| --- | --- |
| **Surgery, injury, or condition**  | **Approximate Year** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Fill in the table below if relevant:**

|  |
| --- |
| Have you used corticosteroids for a long time? If so, for how long and why? |
| Have you had a bone density scan? If so, when and what were the results? |
| Have you had recent weight loss? If so, why? |
| Have you had a recent general check up with your doctor? If so, when and what was the outcome? |

**I hereby consent to treatment by the physiotherapist, and for the relevant medical information to be shared with my medical practitioner.**

**Patient’s signature: ……**…………………………………….

 Revised: 1 June 2019