MOORE HEALTH PHYSIOTHERAPY

Title: Mr Ms Miss Mrs Dr Other:_____ DATE:_____

Surname: _____ First Name: _____

Date of Birth: _____/_____/_____

Mobile: _____ Home / Work Phone:_____

Email Address (*for communication from physio only*)_____

Postal Address: _____

Suburb: _____Post Code: _____

Doctor: _____ Doctor's Address: _____

Occupation:_____ Company:_____

How did you hear about Moore Health and/or who referred you to the clinic?

☐ Friend / Word of Mouth Name: _____

☐ Google ☐ Sign Board ☐ Live in the area ☐ Doctor ☐ Yellow Pages ☐ Other _____

Who is your support network: With your spoken permission your physio may ask to contact people in your support network to help you get on track with your progress

- Partner: Name:_____Number:_____
- Friend: Name:_____Number:_____
- Other: Name:_____ Number:_____

Do you have a fitness instructor? (e.g. personal training, Pilates or yoga)

☐ Yes ☐ No Name: _____Number: _____

Presenting Problem: _____

What is your main problem that you would be most satisfied to fix first?

_____

What is the main function that this problem limits (e.g. *Rotating neck while driving*?)

_____

Cancellation Policy

We require a **minimum 8 hours notice** for changes to or cancellation of your appointment.
If 8 hours notice is not given, the ***full appointment fee will be charged.***

I acknowledge and agree to the above policy.

Signed: _____

Date: _____

Name: _____ Date: _____

Please circle your answer:

1.	Is your general health good?	Yes	No
2.	Do you have any history of disease process such as arthritis, osteoporosis or cancer?	Yes	No
3.	Is there any chance that you are pregnant?	Yes	No
4.	Have you had recent scans or other medical investigations including blood tests?	Yes	No
5.	Have you experienced any unexplained weight loss?	Yes	No
6.	Are you experiencing any bladder or bowel irregularities?	Yes	No
7.	Do you have any tingling, pins and needles or numbness?	Yes	No
8.	Are you experiencing any belly pain or problems?	Yes	No
9.	Do you experience weakness or pain in your legs or balance problems when walking?	Yes	No
10.	Do you have pain in your legs that increases when you walk?	Yes	No
11.	Have you had dizzy spells, nausea, altered vision, fits or fainting episodes?	Yes	No
12.	Have you ever taken steroid pills? (eg cortisone, prednisone)	Yes	No
13.	Have you had a recent fever, chill or recent infection?	Yes	No
14.	Are you currently taking any medications?	Yes	No
	If yes, please specify medications: _____		
15.	Do you have any itchy spots or rashes?	Yes	No
16.	Do you have watery eyes or eye pain with light?	Yes	No
17.	Do you have pain, swelling or redness in other joints?	Yes	No

Patient Privacy Policy

Moore Health takes great care to ensure that our information records are accurate and are treated with full regard to the privacy of our patients.

MOORE HEALTH - Physiotherapists and Massage Therapist