Full Circle Physiotherapy

Patient Details

Surname: .....Given Names: .....
Address: .....
Phone: Home..... Work ..... Mobile .....
Email: ..... Date of birth: ..... /..... /..... Occupation: .....
Emergency Contact Person: ..... Ph: ..... GP.....

Referral Details

Were you referred by your GP? Yes/No
If yes, Which Dr referred you?.....
If no, how did you find out about Full Circle Physiotherapy?.....

Health Details

Please indicate if you have had or presently have problems in any of the following areas:

Cancer	Urinary Tract Infections	Psychiatric	Allergies
Diabetes	Bowel/Bladder Abnormalities	Pneumonia	Emphysema
Thyroid Cond.	Hayfever/Asthma	Migraines	Anemia
Hypoglycemia	Angina/Chest Pain	Hepatitis B	Cirrhosis/Liver Disease
High/Low BP	Stomach Problems	HIV/AIDs	Shortness of Breath
Heart Disease	Arthritis/Gout	Depression	Kidney Disease/Stones
Osteoporosis	Circulatory Disorders	Fractures	Epilepsy/Seizures

Other: (Include recent accidents, traumas and anything pertinent to your health status)
.....
Have you ever had any surgeries? Yes/No
If yes please list with dates .....

Medications: .....
.....

Have you had any prior treatment for you presenting complaint? Yes/No
If yes please list and comment on effectiveness .....
.....

Payment:

Cash/Credit/Debit
Health Fund: ..... Pension/Concession No: .....
Is this injury compensable through:
Work cover?: Yes/No Third Party Compensation?: Yes/No Other?: Yes/No
If yes to any of the above:
Insurance Body: ..... Date of Injury: .....
Employer Name: ..... Phone: .....
Are you eligible to claim through DVA? Yes/No
If yes White Card? Yes/No Gold Card? Yes/No Card No. .....

Medical Release/Informed Consent/Patient Declaration

I authorize the release of medical information to consulting health professionals.
I consent to evaluation and treatment as directed by a licensed Physiotherapist.
I acknowledge that I am responsible for the fees accrued to Full Circle Physiotherapy.
I declare that the information provided to the Physiotherapist is accurate to the best of my knowledge.
Should my claim with a compensable body be denied I will honor my bill in its entirety.
We require 24 hours' notice of cancellation otherwise a cancellation fee will be charged.

Signature: ..... Date: .....