CLIENT REGISTRATION FORM

The following information is confidential. Your accurate and complete information assists to provide the best possible service to you.

CLIENT PERSONAL DETAILS

MR / MRS / MS / MISS / DR

Surname: .....
First Name: .....
Preferred Name: .....
Date of Birth: .....
Address: .....
Suburb: ..... Postcode: .....
Phone: .....
Mobile: .....

Work: .....
Email: .....
Occupation: .....
Health Fund: .....
Health Fund Number: .....
Medicare Number: .....
Emergency Contact Name: .....
Emergency Contact Number: .....

DOCTOR'S DETAILS

Doctor's Name: .....
Doctor's Address: .....
.....

HOW DID YOU FIND US?

- ☐ Yellow Pages
- ☐ Signage
- ☐ Health Fund
- ☐ NDIS
- ☐ Internet
- ☐ Sports Club
- ☐ Family/Friend (Name): .....
- ☐ Doctor/Specialist/Physio/Chiro (Name): .....
- ☐ Advertising (specify): .....
- ☐ Employer/Rehab Co-Ord (Name): .....
- ☐ Other (specify): .....

REASON FOR TODAY'S VISIT

- ☐ Neck
- ☐ Lower Back
- ☐ Elbow
- ☐ Hip
- ☐ Foot/Ankle
- ☐ Mid Back
- ☐ Shoulder
- ☐ Wrist/Hand
- ☐ Knee
- ☐ Pilates
- ☐ Other (specify): .....

DO YOU HAVE A CURRENT WORKCOVER CLAIM FOR THIS INJURY?

☐ Yes ☐ No

Employer: .....
Employer's Address: .....
Date of Injury: .....
Insurer (e.g. EML): .....
Claim Number: .....
Case Manager: .....
Contact Number: .....

DO YOU HAVE A CURRENT MOTOR ACCIDENT CLAIM FOR THIS INJURY?

☐ Yes ☐ No

Date and location of accident: .....
CTP Insurance Company
☐ Allianz CTP ☐ QBE ☐ SGIC ☐ AAMI
☐ Interstate CTP (specify) .....
Claim Number: .....
Case Manager: .....
Lawyer: .....

Please note you will be liable for the cost of any treatment if your claim is not approved or accounts are not paid by the insurer within a reasonable period. Signing this form below indicates you are aware of and accept this condition.

***Please sign to acknowledge you have read and agree to the terms below.**

- **Confidential Information Release:** to assist in your management we may need to send a report to other parties involved in your care. This may include your doctor, case manager or lawyer. By signing this form you authorise us to release information relevant to your treatment.
- I am happy to receive emails re practice changes
- I am happy to receive SMS appointment reminders.
- **Cancellation Policy:** three hours minimum notice is required for cancellation of all appointments. A cancellation fee of $20 will be charged for failure to notify us.
- **Payment Policy:** all accounts with the exception of compensable claims must be paid in full on the day of the treatment. By signing this form you agree to pay any collection fees incurred in recovering any unpaid monies owed to myPhysio myHealth.

SIGNATURE: .....

DATE: .....

PLEASE TURN OVER TO COMPLETE HEALTH QUESTIONNAIRE

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION Member

www.myphysiomyhealth.com.au

MyPhysio MyHealth - Holden Hill
732-734 North East Road
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MyPhysio MyHealth - Woodville
14 Church Street
Woodville South SA 5011
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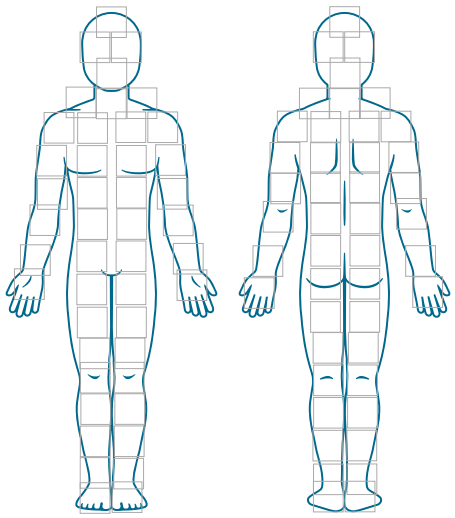
E: receptionwv@myphysiomyhealth.com.au

CURRENT SYMPTOMS

1. Please mark on the body chart your current areas of concern:



2. When and where did this injury occur?

.....

.....

3. Are you off work or limited at work due to this injury?

☐ Yes ☐ No

(Please detail) .....

4. Are you able to perform normal activities of daily living?

☐ Yes ☐ No

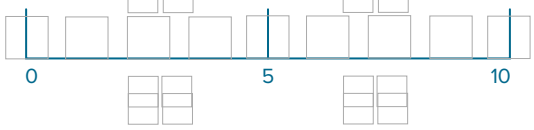
5. Does your current injury affect your ability to exercise or participate in sport?

☐ Yes ☐ No

(Please detail) .....

6. Pain severity (please mark an 'X' on the scale between 0 to 10, with 0 being no pain and 10 being the worst pain imaginable).

What is your pain severity right now?



PREGNANCY HISTORY

1. Are you or could you currently be pregnant?

☐ Yes ☐ No

2. Have you had any previous pregnancies?

☐ Yes ☐ No

If yes how many and when? .....

3. If pregnant, have you been advise of any physical restrictions by your obstetrician/ midwife?

☐ Yes ☐ No

MEDICAL HISTORY

Do you or have you ever had any of the following?

Allergies	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Blood Clots	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Cardiac Problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Digestive Problems (Ulcer, Reflux)	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Headaches/Migraines	☐ Yes	☐ No
Hearing Problems	☐ Yes	☐ No
Hepatitis A	☐ Yes	☐ No
Hepatitis B	☐ Yes	☐ No
Hernia	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Incontinence	☐ Yes	☐ No
Joint Replacement	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Neurological Events (Stroke, TIA, Tumour)	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Unexplained Weight Loss	☐ Yes	☐ No
Vision Problems	☐ Yes	☐ No

Other (please specify) .....

MEDICATIONS

Please list all current medications and any known side effects:

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