

Patient Information Sheet

Please fill in the form and either email to ben@portablephysio.com.au prior to your session or provide completed hardcopy at your next appointment.

YOUR DETAILS	
Name	I prefer to be called
Date of birth	Address
Phone number	Email address
Would you like your doctor informed of your visit? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is your doctor's name and suburb of practice?	
How did you hear about us?	

GENERAL MEDICAL HISTORY	
Do you smoke cigarettes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you diabetic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any infectious diseases?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any psychological disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
During the last month have you been bothered by feeling down, depressed or hopeless?	<input type="checkbox"/> Yes <input type="checkbox"/> No
During the last month have you been bothered by little interest of pleasure in doing things?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please select any of the following that you have now or have ever had :	
<input type="checkbox"/> Heart problems	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Respiratory problems	<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> Neurological disorder	<input type="checkbox"/> Cancer
<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Renal disorder
<input type="checkbox"/> Blood disorder	<input type="checkbox"/> Anaemia
<input type="checkbox"/> Epilepsy/seizures	<input type="checkbox"/> Depression
If applicable, please briefly describe your condition:	
Please list any medications you are currently taking:	
Please list any known allergies you have:	
Please list any other medical or surgical history we should know about:	

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TREATMENT CONSENT FORM

Making an informed decision

We will discuss your condition and options for treatment, outlining the potential benefits and risks, and provide an opportunity for any questions you may have so that you can make an informed decision about your treatment. You may choose to consent or refuse any form of assessment or treatment for any reason, including religious or personal grounds. **You have the right to withdraw your consent at any time, even if you have previously given consent.**

Risks related to treatment

As with all forms of treatments, there are risks and benefits associated with the treatment we provide. We will discuss any foreseeable risks and their likelihood prior to administering the treatment. **You may withdraw your consent at any time, even if you have previously given us your consent.**

Personal questions

The Portable Physio may ask personal questions relating to your injury and how your injury impacts on your life. This information is used to assist us to provide a treatment that meets your needs. It is your choice as to what information you provide in response to these questions. **If you feel uncomfortable with a particular question or group of questions, please let us know and we will cease.**

Physical contact

During the assessment and treatment of your injury it may be necessary for The Portable Physio to make physical contact. We will ask your permission before making physical contact in any way and explain the reason for doing so. Wherever possible, contact will be made using a towel or other form of screening. Physical contact requires your express consent. **You may withdraw your consent at any time, at which point all physical contact will cease immediately. Please inform us if you feel uncomfortable at any time.**

Our rights

We have the right to refuse to provide a service where there are reasonable and non-discriminatory reasons for doing so.

Collection and disclosure of your health information

Your personal health information may be collected, used and disclosed for the following reasons:

- Communicating with other treating medical professionals
- Discussion with third party insurers
- Health insurance procedures
- When consulting with you
- Legal disclosure as required by a court of law.

If you have any concerns with this or wish to restrict access to your information, please discuss these with your physiotherapist.

I have read and understood the "Treatment Consent Form" and offer my consent to receive treatment from The Portable Physio I agree to this consent remaining valid until such a time as I withdraw my consent:

Signed:	Date:

EMERGENCY CONTACT

Name:	Phone Number: