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Physiotherapy Treatment Consent Form & Medical Questionnaire

1. Personal Details

NAME: _____ D.O.B: _____

OCCUPATION:_____

ADDRESS:_____

MOBILE/PHONE:_____

EMAIL:_____

What sports or hobbies do you take part in? _____

Hand Dominance: Right or Left Do you smoke weekly? (Y/N)

2. Medical History

Do you suffer, or have ever suffered from any of the following Y/N? If yes, for how long and/or started when:

LOW, MID BACK, NECK PAIN: _____

SPRAINS/STRAINS: _____

RTA, WHIPLASH &/or HEAD INJURY:_____

FALLS &/or FRACTURES: _____

SURGERY: _____ _____

TENDONITIS: _____

Are you pregnant? (Y/N) If YES, how many months?_____ _____

OTHER: _____

Are you taking any medication? Example: Birth Control Pill, HRT, Asprin, Anti-coagulants, Statins, Steroids, Beta Blockers. Any other medication? Give details_____

Do you suffer from Asthma? (Y/N) Do you have Diabetes? (Y/N) Do you have high/low blood pressure? (Y/N)

Do you have any of the following conditions: High Cholesterol, Hyperlipidemia, Marfans, Ghers-Danos, Rheumatoid Arthritis, Down's Syndrome, Achondroplasia, Hyperhomocysteine, Dermatitis, Eczema? Any other condition(s)?_____

Do you or your family have history of cancer, epilepsy, heart or vascular disease, stroke, neurological problems, osteoporosis or bone disease? (Y/N) If YES, give details:_____

Do you have any metal implants and/or cardiac pacemakers? (Y/N) _____

DECLARATION AND CONSENT
PLEASE READ CAREFULLY BEFORE SIGNING!

I the undersigned agree that the information given above is to the best of my knowledge correct.
I consent to having the Skype consultation recorded.
I understand that the Skype consultation is NOT a full physiotherapy assessment.
I accept that there is a possibility of aggravation of symptoms after the Skype assessments/ consultations.
I agree to pay £25 fee if I cancel less 24 hours of my appointment.

SIGNATURE: _____ DATE: _____