**CLIENT INFORMATION SHEET**

**Date of first attendance: / / .**

**Personal Details**

Mr Mrs Ms Miss

Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Given Names: \_\_\_\_\_\_\_\_\_\_

Address: Postcode:

Telephone: Work- Home- Mob.-

Email: (Tick here if you don’t want to receive emails or newsletters)

Date of Birth: / /

Occupation: Sports/Hobbies:

Next of Kin: Their contact number:

**Payment Method**

□ Private (Health fund name- )

□ Pension/Health Care card □ Veterans Affairs

□ Workers Compensation □ Motor vehicle Accident

**Practice Choice Reason**

How did you find our centre?

□ Friend or relative (Their name? )

□ Saw the sign

□ Yellow Pages (book)

□ Yellow Pages (online)

□ Promotional flyer (Where? )

□ Online search (eg: Google)

□ Facebook

□ Sporting club (Which club are you with? )

□ Doctor (Which Doctor? )

**Please turn over…**

**Precautions**

Do you have/have you had... (Please tick)

□ Cancer or Tumours □ Cardiac Pacemaker □ Diabetes

□ Heart disease □ Lung disease or Asthma □ Metal Implants

□ Neurological condition / Stroke □ Osteoarthritis □ Osteoporosis

□ Rheumatoid Arthritis □ Spinal fractures □ HIV

□ Any other health concerns?

**What is the reason for your visit to us today?**

**WARNINGS**

Please read the following and indicate your understanding by signing below...

**Heat treatment**

When receiving a heat treatment (heat packs or ultrasound), all you should feel is a mild, comfortable warmth. If you feel any more than this, or if the heat concentrates in one particular spot, *notify your physiotherapist immediately*, or you may be in danger of being burned.

**Electrical Stimulation**

When receiving any form of electrical treatment, any discomfort or pain must be *reported immediately to your physiotherapist*, or you may be in danger of an abnormal skin or tissue reaction, which can result in tissue damage.

**Signature-** **Date-** **Witness-**

**RESPONSIBILITY FOR ACCOUNTS**

I acknowledge that I am responsible for the payment of any accounts incurred by me at this Physiotherapy centre. I undertake to pay all accounts in a timely manner.

*\*\*Please note- if you do not attend a scheduled appointment and have not notified us you will not be attending, you will be charged a non-attendance fee\*\**

**Signature-** **Date-** **Witness-**

**Thank you for completing this form, we look forward to being of service to you.**

**WORKERS COMPENSATION DETAILS (if relevant)**

Date of injury Claim number

Employer Contact name

Employer address

Contact phone number

Insurance Company Phone number

Case Manager’s name

SHOULD MY EMPLOYER OR INSURANCE COMPANY NOT ACCEPT LIABILITY FOR MY CLAIM, I WILL PAY ALL OUTSTANDING ACCOUNTS TO THIS PHYSIOTHERAPY CENTRE.

**Signed** **Date**

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**MOTOR VEHICLE ACCIDENTS (if relevant)**

Date of accident Claim number

Case Manager’s name Contact number

SHOULD MY MOTOR VEHICLE INJURY CLAIM NOT BE ACCEPTED BY THE INSURANCE COMPANY, I WILL PAY ALL OUTSTANDING ACCOUNTS TO THIS PHYSIOTHERAPY CENTRE.

**Signed** **Date**