Private Client Details Sheet

Personal Details

Mr / Mrs / Miss / Ms / Dr

Surname _____ Given _____

Email address _____

Postal _____

_____ P/C_____

Ph (H) _____ (M) _____

Date of Birth _____

Occupation _____

Physical Activities _____

Family Doctor _____

Closest Relative _____

Ph (H) _____ (M) _____

We have a regular e-newsletter with lifestyle and injury prevention tips. All clients receive this, please tick if you wish to op out ☐

Referral Details

How did you come to attend our centre?

☐ Doctor _____ (name)
☐ Previous Client
☐ Friend/Family _____
☐ Yellow Pages ☐Local Directory ☐ Newspaper
☐ Talk/Seminar ☐ Walk by ☐ Hospital
☐ Other_____

Pension Details

Type _____
Number _____

Private Health Insurance Details

Name _____
Number _____

Medications

_____
_____
_____
_____
_____

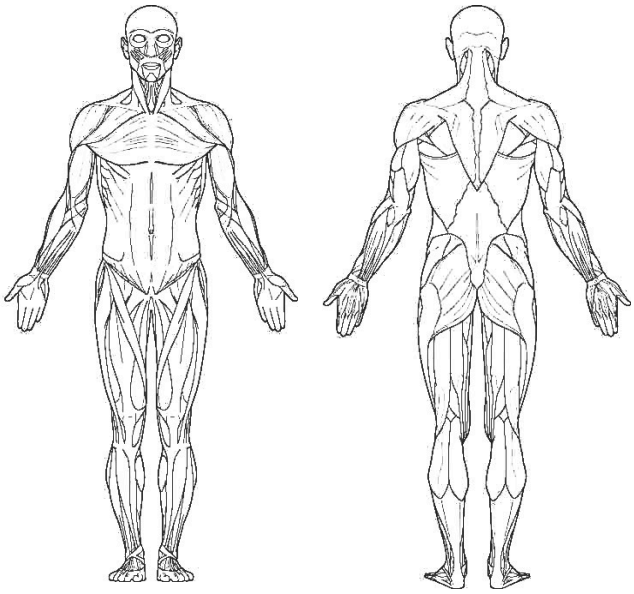
Update Date _____ Sig _____ Witness _____

Update Date _____ Sig _____ Witness _____

Do you have or use any of the following?

High Blood Pressure	Yes ☐
Fit Faint or Funny Turn	Yes ☐
Epilepsy (last seizure ____ /_____ /_____)	Yes ☐
Panic Attacks	Yes ☐
Tumour history	Yes ☐
Asthma	Yes ☐
Allergy to metals	Yes ☐
Diabetes	Yes ☐
Bleeding disorder	Yes ☐
Tuberculosis	Yes ☐
Hepatitis A, B, C, HIV/AIDS	Yes ☐
Pacemaker or other implants	Yes ☐
Heart Valve Replacement	Yes ☐
Autoimmune Diseases	Yes ☐
Mastectomy	Yes ☐
Are you pregnant	Yes ☐
Use Corticosteroids	Past ☐ Current ☐

Pain Map/Description



Please shade your area(s) of pain.

In past 24 hours please grade your;

- Current pain 0 1 2 3 4 5 6 7 8 9 10
- Worse pain 0 1 2 3 4 5 6 7 8 9 10
- Least pain 0 1 2 3 4 5 6 7 8 9 10

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INFORMED CONSENT

Physiotherapy treatment is generally an effective and safe form of treatment however like any treatment there are benefits and risks. The purpose of this form is to let you know what your rights are and how we address the issue of collaborative decision-making and informed consent between you and your physiotherapists.

Your physiotherapists will discuss your condition and options for treatment with you so that you are appropriately informed and can make decisions relating to treatment. You may choose to consent to or refuse treatment for any reason including religious or personal grounds. Once you have given consent you may withdraw it at any time.

Please read the following and sign below;

Your physiotherapist may ask **personal questions** in relation to your injury and how your injury impacts on your activities of daily living. The more information you provide the more likely it is that the physiotherapy can provide an effective treatment. It is your choice as to what information you choose to provide.

During the examination, assessment and treatment it may be necessary for your physiotherapist to make **physical contact.** Where ever possible contact will be made with a towel or other form of screening. Physical contact requires your express consent. You may withdraw consent at any time at which point all physical contact will cease immediately. Please inform your physiotherapist if you feel uncomfortable at any time.

Acupuncture treatment is used in this clinic. It is a form of therapy in which fine needles are inserted into specific body points. Acupuncture is generally safe with serious side effects less than one per 10,000 treatments. Common side effects include drowsiness, minor bleeding (3%), pain during treatment (1%), increased pain after treatment (3%) and fainting. If acupuncture is provided to your trunk there is a possibility of a pneumothorax and your physiotherapist will seek your consent before this treatment is provided. Single use, sterile, disposable needles are only used in this clinic. Allergic **skin reactions** to massage oils, strapping tapes or acupuncture needles are a possibility. **Electro-physical agents** such as ultrasound or interferential therapy have been linked to minor burns and abnormal skin reactions.

Your physiotherapist will discuss any specific foreseeable risks associated with treatment options prior to commencing your treatment and ask for your consent. You may withdraw your consent at any time.

Your **Personal Health Information and your Health Record** may be collected, used and disclosed for the following reasons:

- For communicating relevant information with other treating physiotherapists, GP, specialists or allied health professionals
- Accounting / Medicare / Health Insurance procedures
- Quality Assurance activities such as accreditation
- For disease notification as required by law (e.g. infectious diseases)
- For use by all physiotherapists in this group practice when consulting with you
- For legal related disclosure as required by a court of law (e.g. subpoena, court order, suspected child abuse)
- For research purposes (de-identified, meaning you are not able to be identified from the information given).

If you have any concerns or wish to restrict access to your personal health information please discuss these with your physiotherapist or receptionist. This practice adheres to **National Privacy Principles** (www.privacy.gov.au) and has a written policy, which is available to all clients for inspection.

Consent from a **custodial parent** is required to treat a minor. We recommend a family adult be present during treatment. Where a person is incapable of understanding the risks and benefits of treatment consent may be provided by another person legally authorised to provide such consent. Evidence of legal authorisation is required.

Informed Consent

I _____ have read and understood the statements above relating to consent. I offer consent to receive treatment within this clinic. I agree to this consent remaining valid until such time as I withdraw my consent.

Signed _____ Date _____ Witness _____

Account Responsibility

I _____ acknowledge responsibility for my accounts and agree to pay $8.00 per month fee for accounts overdue by 30 days. Appointments not cancelled incur a did not attend fee.

Signed _____ Date _____ Witness _____