Level 6, 10 Bridge St, Sydney NSW 2000

(02) 9252 2825

www.quayhealth.com.au

PHYSIOTHERAPY HISTORY AND INFORMED CONSENT

ABOUT YOU

Name: Date:

Preferred Name: Date of Birth:

Address:

Postcode:

Phone (H): Mobile: (W):

Email:

Sex: Male ☐ Female ☐

Relationship Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Children (# of):

Emergency Contact: Relationship: Phone:

Occupation: Type of Work:

Have you had previous chiropractic care?: Yes ☐ No ☐ Duration of care:

Name/location of current GP:

Health Fund:

Who may we thank for referring you?:

YOUR LIFESTYLE HABITS

Do you smoke?	Yes ☐	No ☐	If yes, how many cigarettes? _____
Have you ever smoked?	Yes ☐	No ☐	If yes, when you start/give up? _____
Do you drink alcohol?	Yes ☐	No ☐	If yes, how much per week? _____
Do you exercise?	Yes ☐	No ☐	If yes, how much do you exercise per week? _____ _____
Do you have a balanced diet?	Yes ☐	No ☐	Details: _____
Do you have any allergies/sensitivities?	Yes ☐	No ☐	Include food, drugs/medications, herbs and vitamins:_____
Do you have a history of current or past infectious disease?	Yes ☐	No ☐	Details:_____
Have you had any surgery as an adult or child?	Yes ☐	No ☐	Details: _____
Are you currently taking any medication?	Yes ☐	No ☐	If yes, what? When did you start? _____
Are you currently taking any supplements?	Yes ☐	No ☐	Yes, please list: _____ _____
Have you had physical trauma as an adult or child?	Yes ☐	No ☐	Yes, provide details: _____ _____

Rate your level of stress on a scale of 1-10:

Work related: /10 Financial: /10 Family: /10

Main Complaint

Please identify your major health concerns

1. _____
   _____
   How long have you had this problem?_____
2. _____
   _____
   How long have you had this problem?_____
3. _____
   _____
   How long have you had this problem?_____

Have you been given a diagnosis for these problems?_____
What other treatments have you tried and what were the outcomes?_____
_____
_____

Have you had any Xrays/CT scans/MRIs/Ultrasounds or any other medical tests for this condition? If so, what were the results? _____

Are there any other medical conditions that you have been diagnosed with? _____
_____

CHECK AND INDICATE THE AGE WHEN YOU HAD ANY OF THE FOLLOWING:

GENERAL

- ☐ Poor Appetite
- ☐ Hearing Loss
- ☐ Easy to Bleed or Bruise
- ☐ Strong Thirst
- ☐ Puffiness or Swelling
- ☐ Night Sweats
- ☐ Changes in Appetite
- ☐ Weakness
- ☐ Fevers
- ☐ Sweats Easily
- ☐ Poor Sleep
- ☐ Poor Balance
- ☐ Cravings
- ☐ Sudden Energy Drops
- ☐ Chills
- ☐ Fatigue
- ☐ Tremors
- ☐ Weight Loss
- ☐ Weight Gain

SKIN & HAIR

- ☐ Rashes
- ☐ Skin Ulcers
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Hair Loss
- ☐ Recent Moles

RESPITATORY

- ☐ Cough
- ☐ Phlegm
- ☐ Asthma
- ☐ Bronchitis
- ☐ Coughing up Blood
- ☐ Painful Breathing
- ☐ Difficulty Breathing
- ☐ Pneumonia
- ☐ Easily Winded

MUSCULO-SKELETAL

- ☐ Arthritis
- ☐ Muscle Spasms
- ☐ Pain and Weather Changes
- ☐ Muscle Weakness
- ☐ Scoliosis
- ☐ Pain with Activity
- ☐ Muscle Cramping
- ☐ Weak Joints
- ☐ Pain after Waking

HEAD, EYES, EARS, NOSE & THROAT

- ☐ Dizziness
- ☐ Cataracts
- ☐ Taste/smell problems
- ☐ Eye Strain/Pain
- ☐ Nose Bleeds
- ☐ Migraines
- ☐ Recurrent Sore Throat
- ☐ Toothache
- ☐ Ear Ringing
- ☐ Headaches
- ☐ Night Blindness
- ☐ Facial Pain
- ☐ Ear Aches
- ☐ Lip or Tongue Sores
- ☐ Blurry Vision
- ☐ Sinus Problems
- ☐ Concussions
- ☐ Poor Hearing
- ☐ TMJ Pain
- ☐ Spots in Front of Eyes
- ☐ Floaters

GASTRO-INTESTINAL

- ☐ Nausea
- ☐ Bloating
- ☐ Reflux
- ☐ Bad Breath
- ☐ Chronic Laxative Use
- ☐ Indigestion
- ☐ Blood in Stools
- ☐ Constipation
- ☐ Ulcers
- ☐ Vomiting
- ☐ Rectal Pain
- ☐ Hemorrhoids
- ☐ Diarrhea
- ☐ Abdominal Pain
- ☐ Intestinal Gas
- ☐ Belching

UROLOGY

- ☐ Painful Urination
- ☐ Cystitis
- ☐ Decrease in Urine Flow
- ☐ Cloudy Urine
- ☐ Pain in Groin Area
- ☐ Urgency to Urinate
- ☐ Frequent Urination
- ☐ Kidney Stones
- ☐ Sexually Transmitted Disease
- ☐ Unable to Hold Urine
- ☐ Blood in Urine
- ☐ Frequent Night Urination

NEURO-PSYCHOLOGICAL

- ☐ Seizures
- ☐ Twitches
- ☐ Irritability
- ☐ Poor Memory
- ☐ Tremors
- ☐ Areas of Numbness
- ☐ Lack of Coordination
- ☐ Loss of Balance
- ☐ Anxiety
- ☐ Concussion
- ☐ Stress
- ☐ Mood Swings

GYNECOLOGY

- ☐ Irregular Periods
- ☐ Painful Periods
- ☐ Breast Lumps
- ☐ Spotting
- ☐ Vaginal Discharge
- ☐ Clots
- ☐ PMS
- ☐ Menopausal
- ☐ Yeast Infections
- ☐ Fertility Problems

Age of Menses_____

Duration of Menses_____

_____

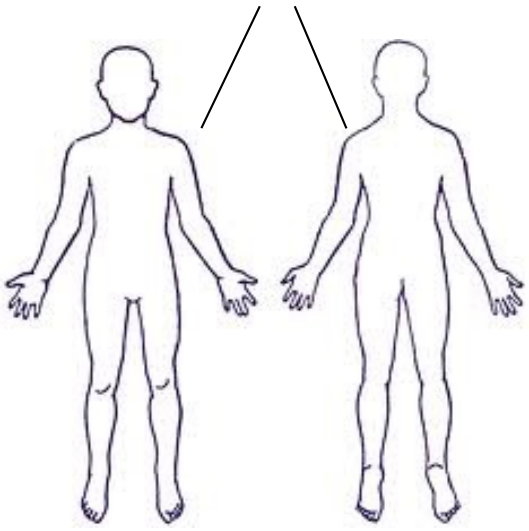
Date of Last Menses _____

_____

# of Pregnancies _____

# of Births _____

Please mark all areas of discomfort in your body.



FRONT BACK

What is your pain/discomfort right now?

|_____|

No pain Worst pain imaginable

What is your typical or average pain?

|_____|

No pain Worst pain imaginable

Informed Consent To Treatment

1. I appreciate that **positive results of any treatment** that I receive at Quay Health and Straight Forward Clinics **is not guaranteed**.
2. I have disclosed any past or current illness, surgery, previous trauma, medications, drug use and any known health risks in the forms and questionnaires provided, and **agree to provide any related new information** during the period of care at this clinic or by practitioners who have assessed or treated me at this clinic.
3. We will be reminding you of appointments via an external SMS service. As well as to keep you informed with the latest information via a monthly newsletter and via SMS periodically. All of which can be unsubscribed to or opted out of at any time.

Risks of Care & Consent for Care

4. Physiotherapy and other techniques used at this clinic are well recognized as being extremely safe health care interventions for people of all ages. However, as with all health care disciplines there is a **risk of complications**. This may include soreness; muscle, bone or joint injury; worsening of symptoms; vision, hearing or balance problems; stroke (estimated at less than 1 per million); or side-effects caused by the use of nutritional or herbal products that may be recommended. **If I have any concerns I will discuss them prior to treatment** or during the course of a treatment program if any new concerns arise.
5. I understand the risks mentioned above. However, **I do not expect the practitioner to be able to anticipate all potential risks and complications** associated with the proposed care.
6. I hereby acknowledge my consent to undergo assessments and treatment at this clinic and understand that I may withdraw my consent at any time.

I have read the above explanation of physiotherapy care. I have also had the opportunity to ask questions and have them answered. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

Printed Name:_____**Signature:**_____**Date:**_____

**If patient is a minor:*

Parent or Guardian Name:_____**Signature:**_____