

**ADVANCED PHYSIOTHERAPY CENTRES Ltd. REGISTRATION FORM**

Please note all information provided will be treated as strictly confidential and will not be passed on to third parties. As part of our quality assurance policy we would like to be able to contact you after completion of your course of treatment in order to assess long term outcomes (e.g. that you remain pain-free one year after physiotherapy treatment) and also to notify you of any changes to our services. Please tick this box if you do not want to be contacted:

**YOUR DETAILS:**

Title: Mr / Mrs / Miss / Ms / Other:

Surname:

Forenames:

Date of Birth:

Age:

Home Address:

Contact Numbers:

Home:

Work:

Mobile:

Email Address:

**NEXT OF KIN DETAILS:**

Name:

Relationship to you:

**GP DETAILS:**

Name:

Contact Number:

Address:

**PRIVATE MEDICAL INSURANCE DETAILS:**

Please complete this section if you intend to claim physiotherapy fees through a Private Medical Insurance (PMI) policy.

PMI Company:

Policy No:

Registration / Authorisation No:

Other details:

Please check details of your PMI policy.

Please note that we are not responsible for any non-payment of claims.

**REFERRAL SOURCE: Word of Mouth / Onsite advertising / Web search / Yell.com / Passed by / GP / Consultant / Other:**

**CONSENT:**

Physiotherapy is a safe and effective form of treatment for musculoskeletal disorders when applied by Chartered Physiotherapists. With certain techniques used in physiotherapy practice a small element of risk is present and you may experience some side effects from treatment. Your Physiotherapist will explain the potential benefits, risks and side effects from the treatment options available to you in order to allow you to make an informed decision. Please sign below to indicate your consent in principle for physiotherapy:

Signed:

**CANCELLATION POLICY:**

Please note that a discretionary 100% cancellation charge will apply if you fail to give 24 hours notice of cancellation or if you fail to attend an appointment.

**DECLARATION:**

I, the undersigned, acknowledge and agree to full and final responsibility for the settlement of my accounts notwithstanding any agreement to settle my accounts by a third party. I understand that I will be charged a discretionary 100% cancellation fee if I fail to give 24 hours notice or fail to attend an appointment.

Signed:

Date:

**GENERAL HEALTH**

(Please circle your response)

- 1. Are you currently feeling fit and well? Yes No
- 2. Are you running a temperature at present? Yes No
- 3. Have you had any illnesses in the last 3 weeks (e.g. cold, flu, infections etc)? Yes No
- 4. Have you experienced any nausea, vomiting or diarrhoea recently? Yes No
- 5. Have you noticed any swelling, lumps or thickening anywhere on your body? Yes No
- 6. Do you have any unhealed sores anywhere on your body? Yes No
- 7. Have you experienced any unexplained weight gain or loss recently? Yes No
- 8. Have you experienced any unexplained sweating recently? Yes No
- 9. Do you experience episodes of dizziness or fainting? Yes No
- 10. Do you currently smoke? Yes No  
If yes indicate number per day \_\_\_\_\_ No of years you have smoked \_\_\_\_\_
- 11. Do you drink alcohol? Yes No  
If yes indicate number of units per week \_\_\_\_\_
- 12. Do you have a pacemaker or transplanted organ? Yes No
- 13. Do you have any metal implants or joint replacements? Yes No
- 14.. Have you had any scans or X-rays recently? Yes No
- 15. Have you had any blood tests or urine tests recently? Yes No
- 16. Have you had any stressful events in your life recently? Yes No
- 17. How much caffeine do you consume daily (tea, coffee, chocolate, soft drinks)?

Please leave this box blank for Therapist )

Response Number	Detail	Initials

**Drug history:**

- 1. Are you taking any prescribed or over-the-counter medications at present?  
If yes please give details below: Yes No
- 2. Have you ever been prescribed with steroids or blood-thinning medication?  
If yes please give details below: Yes No
- 3. Do you use recreational drugs?  
If yes please give details below: Yes No

**Trauma / surgery history:**

- 1. Have you ever sustained any major injuries in the past?  
If yes please give details below: Yes No
- 2. Have you undergone surgery in the past?  
If yes please give details below: Yes No

**PERSONAL / FAMILY MEDICAL HISTORY:**

Please indicate if either you or any immediate family member (parents / siblings only) have been diagnosed with any of the following:

(Please circle your response)

- |  |     |    |
|--|-----|----|
| 1. Cancer                                | Yes | No |
| 2. Diabetes                              | Yes | No |
| 3. Hypoglycaemia (low blood sugar)       | Yes | No |
| 4. Hypertension (high blood pressure)    | Yes | No |
| 5. Hypotension (low blood pressure)      | Yes | No |
| 6. High Cholesterol                      | Yes | No |
| 7. Cardiac disease                       | Yes | No |
| 8. Angina or chest pain                  | Yes | No |
| 9. Shortness of breath                   | Yes | No |
| 10. Stroke                               | Yes | No |
| 11. Kidney disease / stones              | Yes | No |
| 12. Urinary tract infection              | Yes | No |
| 13. Allergies                            | Yes | No |
| 14. Asthma / hay fever                   | Yes | No |
| 15. Rheumatic / scarlet fever            | Yes | No |
| 16. Rheumatoid arthritis                 | Yes | No |
| 17. Osteoarthritis                       | Yes | No |
| 18. Lupus                                | Yes | No |
| 19. Hepatitis / jaundice                 | Yes | No |
| 20. Liver disease / cirrhosis            | Yes | No |
| 21. Polio                                | Yes | No |
| 22. Chronic bronchitis                   | Yes | No |
| 23. Pneumonia                            | Yes | No |
| 24. Emphysema                            | Yes | No |
| 25. Tuberculosis                         | Yes | No |
| 26. Migraine / headaches                 | Yes | No |
| 27. Anaemia                              | Yes | No |
| 28. Ulcers / stomach problems            | Yes | No |
| 29. Depression                           | Yes | No |
| 30. Anxiety / panic disorder             | Yes | No |
| 31. Chemical dependency (alcohol, drugs) | Yes | No |
| 32. Gout                                 | Yes | No |
| 33. Haemophilia / slow healing           | Yes | No |
| 34. Guillain-Barre syndrome              | Yes | No |
| 35. Epilepsy                             | Yes | No |
| 36. Thyroid problems                     | Yes | No |
| 37. Multiple sclerosis                   | Yes | No |
| 38. Fibromyalgia                         | Yes | No |
| 39. Osteoporosis / osteopenia            | Yes | No |
| 40. Ankylosing Spondylitis               | Yes | No |
| 41. Parkinson's                          | Yes | No |
| 42. Other                                | Yes | No |

(Please leave this box blank for Therapist)

Initials:

**WORK HISTORY**

1. What is your current occupation? (write 'student' if you are in full-time education):

Please indicate how many months / years you have worked in this occupation:

2. Please list occupations you have held in the past and the number of years worked in each occupation:

3. Please indicate the number of hours you work / study per week:

4. Please indicate what percentage of the day you spend:

sitting                      driving                      lifting / carrying                      standing                      walking

5. Are you currently off work / study due to illness or injury?                      Yes                      No                      N/A  
 If yes: What are you off sick for?

When are you expected to return to work?

6. Please indicate the dates of any previous episodes of being unable to work / study due to illness or injury:

Date	Absence duration	Reason for absence	Outcome (i.e. full recovery / partial recovery)

7. Have you had a work-station assessment ?                      Yes                      No                      N/A

8. Have you had a risk assessment?                      Yes                      No                      N/A

9.. Are you on light duties or reduced hours at present?                      Yes                      No                      N/A

10. Have you had your eyes tested in the last two years?                      Yes                      No                      N/A

11. Does your job involve the repetitive use of light equipment e.g. phone, mouse?                      Yes                      No                      N/A

12. Does your job involve the use of heavy equipment?                      Yes                      No                      N/A

13. Does your job involve lifting, bending, twisting or climbing?                      Yes                      No                      N/A

14. Does your job involve exposure to chemicals?                      Yes                      No                      N/A

(Please leave this box blank for the Therapist)

Response Number	Detail	Initials

**EXERCISE & SPORT HISTORY / CURRENT LEVEL OF FITNESS**

1. Are there currently any injuries / illnesses / medical conditions preventing you from or limiting your participation in exercise?  
Yes                      No

If Yes what is limiting your activities?

How have your activities been affected?  
 (continue overleaf if necessary)

2. Please list the physical activities, exercise and sports you perform regularly:

Activity (i.e. gardening, walking, running, gym, football, DIY, play with children, classes)	Duration (i.e. length of time you exercise for each episode)	Frequency (i.e. how often do you perform this type of exercise?)	Intensity (i.e. how hard you are working whilst performing the exercise)	Current ability to perform this exercise (i.e. Unrestricted / Partially restricted / Fully restricted)

3. Please tick the response that best describes your attitude to exercise throughout your life:

I have always kept myself fit and active and usually exercise 4-7 times per week.

I try to keep myself fit and active and usually exercise 1-3 times per week but often lack the time to do any more.

I exercise less than 1-3 times per week and lack the time / willpower to fit regular exercise into my life.

I exercise sporadically, some months I exercise regularly, other months I achieve minimal exercise.

I do not enjoy exercise and try and avoid it wherever possible.

4. Please describe any changes you have made to the way you exercise i.e. increasing intensity, duration, frequency, new trainers, new exercises etc:  
 (continue overleaf if necessary)

5. How would you rate your current level of fitness? (circle your response):

Never been fitter                      Normal level of fitness                      Less fit than normal                      Totally unfit

6. If your response to question number 6 was Less fit than normal or Totally unfit, when was the last time you would consider yourself to have had a good level of fitness?

7. What exercise / fitness / lifestyle goals would you ideally like to achieve?