Full Circle Physiotherapy

Patient Details

Surname: …….. Given Names: ……

Address: ……

Phone: Home: ……..…. Work: ..……. Mobile: ……..
(Please circle your preferred contact number)

Email: ……..…. Date of birth: …../…../….. Occupation: ……

Emergency Contact Person: ……..…… Ph: …… GP: ….……

Sex assigned at birth: Male/Female/Other (please specify):……

Gender Identity: Male/Female/Trangender Male/Transgender Female/Gender Queer

Preferred pronouns (circle): She / Her / Hers
He / Him / His
They/Them/Theirs
Others: (please specify)

Referral Details

Were you referred by your GP? Yes/No

If yes, which Dr referred you?.....

If no, how did you find out about Full Circle Physiotherapy?.....

Health Details

Please circle if you have had or presently have problems in any of the following areas:

Cancer	Urinary Tract Infections	Psychiatric	Allergies
Diabetes	Bowel/Bladder Abnormalities	Pneumonia	Emphysema
Thyroid Cond	Hayfever/Asthma	Migraines	Anemia
Hypoglycemia	Angina/Chest Pain	Hepatitis B	Cirrhosis/Liver Disease
High/Low BP	Stomach Problems	HIV/AIDs	Shortness of Breath
Heart Disease	Arthritis/Gout	Depression	Kidney Disease/Stones
Osteoporosis	Circulatory Disorders	Fractures	Epilepsy/Seizures
Neurological Condition			

Other health related conditions: (Include recent accidents, traumas and anything pertinent to your health status)

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Have you ever been diagnosed with Post Traumatic Stress Disorder? Yes/No

Have you ever had any surgeries? Yes/No

If yes, please list with dates:

……..…….

……

Medications:

……..…….……

……..……

……..

Have you had any prior treatment for you presenting complaint? Yes/No

If yes, please list and comment on effectiveness

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Payment

Cash/Credit/Debit……..

Private Health Fund: Yes/No (If yes list fund details)

……..……...

Are you eligible to claim through DVA? Yes/No

If yes, do you have a referral form your Dr ……

NDIS/Aged Care Package Yes/No (if yes, relevant details including case # and billing details)

…….

Medicare (Enhanced Primary Care Program) Yes/No

***I authorise the release of medical information to or from consulting health professionals.**
***I consent to evaluation and treatment as directed by a licensed Physiotherapy.**
***I acknowledge that I am responsible for the fees accrued to Full Circle Physiotherapy.**
***I declare that the information provided to the Physiotherapist is accurate to the best of my knowledge.**
***I acknowledge the 24 hours' notice of cancellation/non-attendance policy. I agree to pay in full the cancellation fee of the cost of the missed visit prior to rebooking.**

Signature: …….. Date: ……