# Full Circle Pelvic Physio and Clinical Sexology

## 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: ….……

Are you of Aboriginal or Torres Strait Islander origin? …….No/ Yes……..

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

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

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 | Hay fever/Asthma | Migraines | Anaemia |
| Hypoglycaemia | 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 | Stroke | | |

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

……

……

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

……

……

**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 50 % of the cost of the missed visit prior to rebooking if appropriate notification not provided.**

Signature: …….. Date: ……