Please complete this form & e-mail to adam@newforestphysio.co.uk PRIOR to first appointment.

NAME: DATE OF BIRTH: DATE:

PLEASE COMPLETE ALL 5 PAGES PRIOR TO FIRST APPINTMENT

******IMPORTANT UPDATE******

On 1st January 2024 the clinic relocated to

40 Kingfisher Way, Marchwood, Southampton SO40 4XS

For directions visit http://www.newforestphysio.co.uk/marchwood-40-kingfisher-way/

PHYSIOTHERAPY CONSENT FORM

Terms and Conditions of treatment at New Forest Physiotherapy Clinic Southampton

1) I give consent to physiotherapy assessment and treatment at New Forest Physiotherapy Clinic Southampton.

2) I understand that if I fail to attend an appointment with out providing 24 hours notice I will be charged for that appointment or will loose one of my insurance appointments.

3) I consent to my physiotherapist contacting my GP/consultant/other medical professional if necessary. We will inform you if we need to contact them.

4) I consent to New Forest Physiotherapy Clinic contacting me with appointment reminders, exercise sheets, clinical letters and newsletters about important clinic business (eg if your appointment needs to be rearranged) as necessary. You can unsubscribe from newsletters whenever you like.

5) INSURANCE PATIENTS: I agree to pay any insurance excess at my first appointment or when invoiced by New Forest Physiotherapy Clinic.

6) SELF FUNDING PATIENTS: I agree to paying the following physiotherapy fees;
Assessment 1 hour £65
Treatment 30 mins - £45
Pre-payment package 6 treatment sessions for the price of 5 - £225 (£37.50 per session)

Patient / Guardian Signature: ……..…

Date: ……..

Physiotherapist: Adam Smith-Connor

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Health Check List

Please complete this health-screening questionnaire, which will help us to assess your needs.

Do you suffer from any of the following conditions / symptoms?

Delete as appropriate (If yes please provide full details below)

Diabetes (Type I or type II)	Yes	No
Epilepsy	Yes	No
Headaches or migraine	Yes	No
Heart conditions (eg angina, heart attack, heart murmur)	Yes	No
Lung conditions (eg asthma, bronchiectasis, COPD, tuberculosis)	Yes	No
Haemophilia / taking blood thinners	Yes	No
Cancer	Yes	No
HIV	Yes	No
Bone Conditions (eg osteoporosis, RA)	Yes	No
High blood pressure	Yes	No
Low blood pressure	Yes	No
Back pain	Yes	No
Muscle, nerve or joint problems	Yes	No
- E.g. arthritis, repetitive strain injury,		
- Recurrent injuries, carpel tunnel syndrome		
Stroke or head injury	Yes	No
Genetic disorders (eg cystic fibrosis, muscular dystrophy)	Yes	No
Neurological conditions (eg MS, Guillain Barre syndrome)	Yes	No
Unexplained weight loss	Yes	No
Abnormal bowel or bladder function (E.g. constipation/diarrhoea/urinary incontinence/retention)	Yes	No
Muscle Weakness (E.g. dropping things/dragging your feet)	Yes	No
Difficulty Speaking (E.g. slurred speech, difficulty finding the right words)	Yes	No

New Forest Physiotherapy Clinic Ltd
40 Kingfisher Way, Marchwood, Southampton SO40 4XS
Appointment line: 023 8008 9120
Physiotherapist Adam: 07500 392 321
Clinic Administrator Colette: 07867 563 952

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Double Vision	Yes	No	
Mental health problems (eg. depression, anxiety)	Yes	No	
Dizziness, labarynthitis or vertigo	Yes	No	
Are you currently pregnant / think you might be pregnant?	Yes	No	N/A
Have you fractured any bones in the past?	Yes	No	
Do you have any metal implants	Yes	No	
Do you have a pacemaker	Yes	No	
Do you suffer from any allergies	Yes	No	

Please list any operations you have had with dates.

Please list all your current medications (including blood thinners and steroids).

Please use this space to list any other conditions, not already mentioned above.

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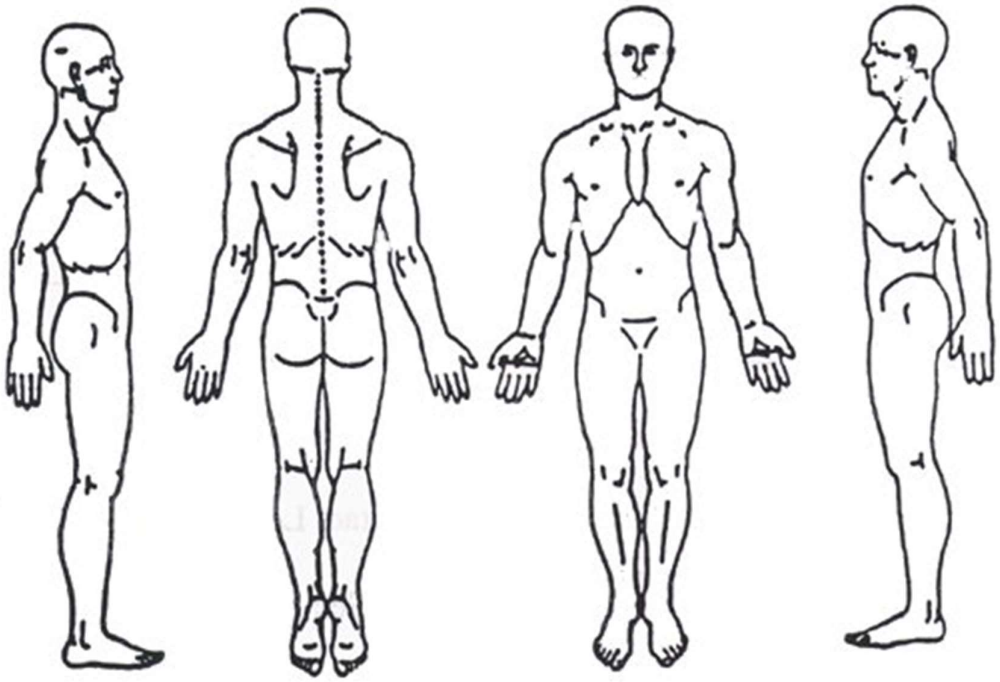
Please explain the reason for your visit (e.g. back pain/unable to reach up, etc.)

Where does your pain occur? (Please mark on the diagram below with an 'X' & describe below)

Please score each area of pain (on the diagram) from: 0 (No pain) to 10 (Extreme pain)
Please mark on the any areas of numbness or pins and needles with an 'O'



Describe your pain (throbbing, burning, aching, stabbing, etc)

When did this pain begin? Please provide approximate date.

What caused your pain? (E.g. Car crash, fall, repetitive movement, sport, unknown, etc.)

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What activities worsen the pain? (E.g. bending, heavy lifting, sneezing, reaching up, etc.)

What relieves your pain? (E.g. Pain killers, hot water bottle, stretching, etc.)

Have you had any previous treatment for this problem? (If yes, please provide details below)

Please rate your pain on severity from 0 (No pain) to 10 (Extreme pain), at these different times of the day: (Please circle)

Morning	Afternoon	Evening
0 1 2 3 4 **5** 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

Has the pain affected your sleep in any way? YES NO

Have you had any investigations into your pain? YES NO
(E.g. X-Ray, MRI scan, ultrasound, blood test, etc. If yes, please provide details below)

What do you do for a living?

List any regular sports or hobbies you do