Registration Document

Physio where you are

Specialist Mobile Neurological Physiotherapy Service

FIRST NAMES ____

SECOND NAMES ____

ADDRESS ____

____

____

POST CODE ____________________

E-MAIL ADDRESS ____

HOME PHONE ____

WORK PHONE ____

MOBILE PHONE ____

DATE OF BIRTH _____ / _____ / _____

AGE _______

Diagnosis (If available)

DIAGNOSIS ____

DATE OF DIAGNOSIS/ONSET ____

CT &/or MRI SCAN RESULTS ____

GPs NAME ______________________________

ADDRESS ______________________________

____

____

PHONE NUMBER ______________________________

Consultant Details (If available)

CONSULTANTS NAME ______________________________

DATE OF NEXT APPOINTMENT ______________________________

HAVE YOU HAD ANY FORM OF THERAPY FOR THIS CONDITION BEFORE? YES / NO

If yes, please give a brief summary of who provided the treatment, the type of treatment and whether it was helpful.

____

____

____

DO YOU CURRENTLY TAKE ANY PRESCRIBED MEDICATION?

NAME OF MEDICATION ______________________________

____

WHAT IT IS FOR ______________________________

____

PAST MEDICAL HOSTORY

Do you have or have you suffered from any of the following conditions? (Please tick)

___ Epilepsy
___ Diabetis
___ Asthma
___ Heart Disease
___ Pain
___ Cancer
___ Osteoporosis
___ Rheumatoid arthritis

___ Hearing difficulty
___ Sight problems
___ Spasms
___ High tone/spasticity
___ Clonus
___ Low Blood Pressure
___ High Blood Pressure

HAVE YOU EVER HAD ANY SERIOUS ILLNESSES OR INJURIES OR BROKEN ANY BONES? YES NO (Please circle)

PLEASE GIVE DETAILS ____________________

____

____

____

SOCIAL HISTORY

WHAT TYPE OF ACCOMMODATION DO YOU LIVE IN? ____________________
(eg house , flat, bungalow)

If you have stairs, can you manage them? YES NO (Please circle)

Do you have family or carers living with you? YES NO (Please circle)

Please indicate here who is living with you: ____________________

____

____

DAILY TASKS

Do you require help with:
Washing YES some aspects YES all of it NO (Please circle)

Dressing YES some aspects YES all of it NO (Please circle)

Preparing meals YES NO (Please circle)

WORK

Do you currently work? YES NO (Please circle)

If NO, was this current condition the cause of you stopping work?
YES NO (Please circle)

YOUR AIMS AND GOALS

IT WOULD BE HELPFUL IF YOU COULD LIST WHAT YOU SEE AS YOUR CURRENT MAIN PROBLEMS WHICH ARE AS A RESULT OF YOUR CURRENT CONDITION

1) ____

2) ____

3) ____

4) ____

DO YOU HAVE ANY SPECIFIC AIMS OR GOALS THAT YOUR PHYSIOTHERAPY TREATMENT WILL HELP YOU TO REACH?

1) ____

2) ____

3) ____

4) ____

CONSENT

In order for us to assess and treat your condition, we will require consent from you.
You will be consenting to physiotherapy assessment and treatment that falls within the professional boundaries as set by the Chartered Society of Physiotherapy and the Health Professions Council.
The assessment and treatment process will involve appropriate techniques, some of which involve the therapist handling you. You can expect to be kept fully informed throughout all assessment and treatment procedures so that you know what is planned and how it will be carried out. You are at liberty to withdraw your consent at any time BUT YOU MUST INFORM THE THERAPIST OF THIS DECISION IMMEDIATELY.
If you feel that any aspect of treatment has not been adequately explained, please ask for further information and immediate clarification will be provided.

I have read the consent notice above and understand that by proceeding with the initial assessment and subsequent treatment(s), I am giving my consent to appropriate assessment and treatment. I understand that it is within my rights and it is my responsibility, to withdraw consent for any treatment that I do not consider to have been fully informed about or that I choose not to continue with.
I understand that I must inform my therapist IMMEDIATELY that I am withdrawing consent.

Signature: ______________________________________

Name (print): ______________________________________

Date: ____________________