



Physio where you are

Specialist Mobile Neurological Physiotherapy Service

ANY QUESTIONS PLEASE CALL!
MOBILE:0780 430 9667
TEL 01283 735252

DATE OF INITIAL ASSESSMENT _____

SURNAME _____ FIRST NAME _____

PREFERRED NAME _____

ADDRESS _____

_____ POST CODE _____

E.MAIL _____

HOME PHONE _____ MOBILE _____

DATE OF BIRTH _____ AGE _____

DIAGNOSIS _____

DATE OF ONSET _____

SCAN: CT &/OR MRI DATE & RESULTS _____

CONSULTANTS NAME _____

DATE OF NEXT APPOINTMENT _____

GPs NAME _____ GPs TEL _____

GPs ADDRESS _____



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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? YES / NO
NAME OF MEDICATION WHAT IT IS FOR

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

If you take a lot of medication, it may be helpful for you to ask your GP for a printed out list.

PAST MEDICAL HISTORY

Do you have or have you suffered in the past from any of the following conditions?

- | | | |
|---|--|---|
| <input type="checkbox"/> Hearing difficulty | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Muscle spasms |
| <input type="checkbox"/> Sight difficulties | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High muscle tone |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Spasms |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Clonus |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Epilepsy |



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HAVE YOU EVER HAD ANY SERIOUS ILLNESS OR INJURIES OR BROKEN ANY BONES?
YES / NO

If yes, please give dates & details _____

PAIN

DO YOU HAVE ANY PAIN? YES / NO

If yes, where is it? _____

What makes it worse? _____

What eases it? _____

Describe how it feels _____

FALLS

HAVE YOU FALLEN? YES / NO

If yes, what causes you to fall? _____

When did you last fall? _____ How often do you fall? _____

SOCIAL HISTORY

WHAT KIND OF ACCOMMODATION DO YOU LIVE IN? _____

Eg. House, flat, bungalow



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SOCIAL HISTORY

If you have stairs, can you manage them? YES / NO

Do you have family or carers living with you? YES / NO

If yes, 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 some aspects YES all of it NO (please circle)

WORK/HOBBIES

Do you currently work? YES / NO (please circle)

If no, was your current condition the cause of you stopping work? YES / NO (please circle)

If yes, what is your current role in the work place? _____

What are your current hours of work? _____

Do you have any hobbies? YES / NO (please circle)

Are you currently able to partake in them? YES / NO (please circle)



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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 out 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. You will 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 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 _____ Date _____

Name (print) _____ I consent to treatment YES NO (please tick)