This form saves time during the initial assessment by getting some of the formalities sorted prior to our meeting at the initial assessment. We realise that it can be difficult to answer some of the questions. There may be others that you choose not to answer. No problem! We will discuss the form with you at the assessment session and clarify any queries you might have. If you have any questions, then call or e-mail us (info@physiowhereyouare.co.uk).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| First Name |  | Second Name |  | |
| Preferred Name |  | DOB |  | |
| Address  Postcode |  | | | |
| Email |  | Tel. no. | |  |
| Next of Kin (name and contact no.) |  | | | |
| GP name &  address |  | | | |
| Your Consultant (if applicable) |  | | | |

Diagnosis and date of onset

|  |
| --- |
|  |

Past Medical History

|  |
| --- |
|  |

Medications (if you have a list from your GP we can go through this on your assessment)

|  |
| --- |
|  |

Please state why you would like to have Physiotherapy

|  |  |
| --- | --- |
| I want to improve my function | *Tick if this applies* |
| I want to prevent deterioration in my condition | *Tick if this applies* |
| I want to reduce my pain | *Tick if this applies* |
| Other (please add specific comments below) | *Tick if this applies* |
| *Comments* | |

Have you had any other input for your condition? Please indicate below:

|  |  |
| --- | --- |
| Physiotherapy | YES/NO |
| Consultant Review | YES/NO |
| Hydrotherapy | YES/NO |
| Botulinum toxin injection | YES/NO |
| Orthotics | YES/NO |
| Other Therapy – OT/SLT | YES/NO |
| Anything else – if yes please comment below | YES/NO |

Please circle any of the above which you found beneficial.

What are the main symptoms you experience with your condition?

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| --- |
|  |

Do you have any pain? YES/NO

If yes, please state where.

|  |
| --- |
|  |

Have you had any falls? If yes, when was the last fall?

|  |
| --- |
|  |

Do you need help with the following:

To get washed and dressed? YES/NO

To prepare your meals? YES/NO

To do your shopping? YES/NO

If yes who provides this help for you?

|  |
| --- |
|  |

Do you have carers who come into your home to help you? YES/NO

If yes how often do they come and what do they help you with?

|  |
| --- |
|  |

Work

Are you currently at work? Yes/No

If no, does your condition affect your ability to work?

If yes what is does your work involve? Does your condition affect your work?

Hobbies/Leisure

What do you enjoy doing?

|  |
| --- |
|  |

Does your condition stop you doing some of these things? YES/NO

Do you feel low in mood or anxious at times? YES/NO

If yes, what can make you feel like this?

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| --- |
|  |

Are there particular days or times in the week that would suit you better?

|  |
| --- |
|  |

What goals would you like Physiotherapy input to help you achieve?

|  |
| --- |
|  |

Any final comments

|  |
| --- |
|  |

**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)

*Thank you for completing this form. Your therapist will contact you to arrange the date and time of your assessment if they have not already done so.*