



PATIENT REGISTRATION FORM

Today's date: _____

This information is collected for the purpose of providing you with the best treatment possible. If you have any questions about how we use your information, please let us know. **Please print clearly.**

First name: _____ Surname: _____

Preferred name we call you: _____

Date of Birth: _____ Occupation: _____

Phone number: _____

Email: _____

Street Address: _____

Suburb: _____ Postcode: _____

Parent/Guardian/Carer name & contact, if required:

Do you have a disability or health condition that requires us to adjust how we provide our services?
 No Yes, details:

Gender: She/Her He/Him They/Them
 Other:

Do you have Private Health Insurance? Yes No
If yes, Fund name: _____

Your Doctor's Name: _____

Your Doctor's address/clinic: _____

Do you give permission for us to send a letter to your Doctor confirming you have started treatment?
 Yes No

Emergency Contact: _____ Relationship: _____ Phone: _____

Please turn over

How did you hear about this clinic?

- | | |
|---|---|
| <input type="checkbox"/> Friend/Family: _____ | <input type="checkbox"/> Street Signage |
| <input type="checkbox"/> Google Search | <input type="checkbox"/> From my doctor |
| <input type="checkbox"/> HealthEngine | <input type="checkbox"/> From my Personal |
| <input type="checkbox"/> Facebook/Instagram | Trainer: _____ |
| <input type="checkbox"/> Sports club/gym: _____ | |

What are the most important things you want to get out of today's session?

What is the problem stopping you from doing? (e.g. sleeping, sport, household chores)

Please tell us if you have (or previously had) any of the below, so we can provide you with safe and effective treatment:

- | | | |
|--|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Spinal surgery | <input type="checkbox"/> A pacemaker |
| <input type="checkbox"/> Spinal fracture | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Heart attack / problems | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Dislocations |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other surgeries | <input type="checkbox"/> An aneurysm |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Psoriatic arthritis | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Ankylosing spondylitis | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Ligament injuries |
| <input type="checkbox"/> Cartilage injuries | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Strokes / Blood clots |

Do you take any blood thinners? (e.g. aspirin, warfarin) Yes No

Do you take any oral steroids? Yes No

Are you Claiming through Worker's Compensation or Motor Vehicle Accident Insurance?

No Yes - complete below:

Date of Injury:	Claim #:
Insurer:	Insurer's Address:
Contact person:	Phone:
Employer:	Employer's Address:
Case Manager (if any):	Case Manager Phone:
Treatment # (if any):	

IMPORTANT: I understand that I will need to give **24 hours notice** when rescheduling or cancelling an appointment. This clinic operates with a cancellation fee equal to the cost of the appointment.

Informed Consent

I consent to the assessment and treatment recommended and performed by *Swan Physiotherapy* in accordance with the governing body's professional guidelines. This may include joint mobilisations, manipulation, manual therapy techniques, soft tissue massage, dry needling and/or electrotherapy modalities. I understand that before treatment is carried out, a full explanation of the purpose and any risks of that treatment will be provided. I understand that should I wish to decline any form of assessment or treatment, then I am entirely within my right to do so and that I should inform the clinician of my wishes at the time. *Swan Physiotherapy* accepts no responsibility for treatment received - any professional liability is between the patient and the individual treating therapist - all physiotherapists are insured via their own personal policies. I understand that if I do not provide *Swan Physiotherapy* with relevant past or current medical information that this may affect the clinicians ability to provide safe and effective treatment. By signing this form I am in agreement with these terms and conditions.

Patient Signature:

Date: