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?

☐ Friend/Family:__________________________
☐ Google Search
☐ HealthEngine
☐ Facebook/Instagram
☐ Sports club/gym:_________________________
☐ Street Signage
☐ From my doctor
☐ From my Personal Trainer:___________________________________

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:

☐ Cancer
☐ Spinal fracture
☐ Heart attack / problems
☐ Diabetes
☐ High blood pressure
☐ Ankylosing spondylitis
☐ Cartilage injuries
☐ Spinal surgery
☐ Thyroid problems
☐ Osteoporosis
☐ Other surgeries
☐ Psoriatic arthritis
☐ Lung problems
☐ Epilepsy
☐ A pacemaker
☐ Osteoarthritis
☐ Dislocations
☐ An aneurysm
☐ Rheumatoid arthritis
☐ Ligament injuries
☐ 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:
Case Manager (if any):	Case Manager Phone:
Employer:	Employer's Address:
Contact person:	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: