

Claim Number: _____

Injury: _____

GENERAL PATIENT INFORMATION

The following information is required so we can uniquely identify you, supply accurate information to ACC about your injury (where required) and provide statistical data in the use of national health planning and policy.

Full Name: _____
Postal Address: _____
Home Phone: _____ Work Phone: _____
Mobile: _____ Date of Birth: _____
Email address: _____ Would you like to receive our newsletter? _____
Ethnicity: _____ Usual GP: _____
Occupation: _____ Employer: _____
Employers Address: _____

Please tell us who you would like us to contact, in the event of an emergency

Name: _____ Relationship to you _____

Contact details: _____

Your information is helpful to us, however the following 2 questions are for statistics only and not compulsory

How did you hear about us? Previous Patient Word of mouth Yellow Pages Local directory Don Oliver's
 Observer Signage Flier Doctor Specialist Other (please specify): _____

Why did you choose us? Reputation No cost Location Hours Able to get appointment GP referred me
 ACC Accredited Advertising First one I called No particular reason
 Other (please specify): _____

Information referral to a 3rd party other than my GP:

I consent to the disclosure of my records, to any person / organisation necessary for the effective management of my condition.

I consent to a discharge/update report being sent to my doctor/medical clinic

TERMS OF ENGAGEMENT – YOUR AGREEMENT IS NECESSARY BEFORE TREATMENT PROCEEDS

Clinic Brochure:

I have read and understood the KCP Physiotherapy clinic brochure.

Agreement to Pay:

I understand that I am liable to pay

- For treatment charges and the costs of materials (splints, collars etc.)
- Any treatments declined by ACC or any other funder
- A **non-attendance fee of \$39.00**, if I fail to notify KCP Physiotherapy at least 6 hours in advance to cancel a scheduled appointment, or if I do not attend a scheduled appointment
- A \$50.00 call out fee should I require a Physiotherapist to visit me outside of clinic hours

Please complete the following section **after** consultation with your Physiotherapist

INFORMED CONSENT TO TREATMENT

Where relevant to my treatment plan, the following have been explained to me and I have had an opportunity to ask questions. I understand that I have the right to decline part or all of the treatment offered to me at any time. I understand my treatment plan and consent to being treated by a KCP Physiotherapist.

Electrotherapy Manipulation Mobilisation Acupuncture

Signature: _____

Date: _____

(if under 16, must be signed by parent/guardian)

GENERAL INFORMATION

What medication are you taking, if any?	
What sport do you play?	
What fitness do you do, include any kind of fitness training and general e.g. gardening, walking the dog, golf	
General Health: Do you have any health issues that we should know about, e.g. diabetes, heart, cancer history?	
Social/other: Do you smoke or drink?	
Work: What are your general work duties?	
If under 16: What are your mum and dad's name?	
Tick any you suffer from presently or have suffered from in the past?	<input type="checkbox"/> Dizziness <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Fainting <input type="checkbox"/> Double vision <input type="checkbox"/> Slurred speech <input type="checkbox"/> Nausea <input type="checkbox"/> Numbness in tongue <input type="checkbox"/> Eye movement problem <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Cancer <input type="checkbox"/> Heart <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Joint replacement <input type="checkbox"/> Arthritis <input type="checkbox"/> HIV <input type="checkbox"/> Hep. C

Treatment Plan

- Every injury requires a set of Treatment Goals that are used to monitor your progress
- Treatment Goals are based around normal daily functions that you do
- Once your Treatment Goals have been achieved, your treatment stops
- From time to time the Treatment Goals may need to be adjusted to accommodate new information that comes to light over the course of your treatment

Write some specific goals that you can personally use to measure your progress or specific things that you currently cannot do as a result of your injury 0 is bad, 100 is excellent	
Specific Activity	Indicate how you feel at the moment doing this particular activity
e.g. Get out of bed without pain	0 10 20 30 40 50 60 70 80 90 100
e.g. Lift my arms to hang out the washing	0 10 20 30 40 50 60 70 80 90 100
e.g. Walk the dog for ½ an hour	0 10 20 30 40 50 60 70 80 90 100
	0 10 20 30 40 50 60 70 80 90 100
	0 10 20 30 40 50 60 70 80 90 100
	0 10 20 30 40 50 60 70 80 90 100
	0 10 20 30 40 50 60 70 80 90 100
	0 10 20 30 40 50 60 70 80 90 100
	0 10 20 30 40 50 60 70 80 90 100