THE PHYSIO STUDIO

PERSONAL DETAILS					
Title		Sex M / F	Date of birth	/ / AGE:	
First Name			Emergency contact name & number		
Surname					
ADDRESS					
House No			Home phone		
Road/ Street			Mobile Number		
Area/ Town					
County			Email address		
Post Code					
GP / CONSULTANT					
Surgery Name			GP Name		
Surgery Address or Location			Surgery Site		
Consultant Name			Specialty		
Consultant's Hospital					

MY **REFERRAL SOURCE:**	**WHY I CHOSE** THE PHYSIO STUDIO:
☐ I REFERRED **MYSELF** ☐ MY **GP** REFERRED ME ☐ MY **CONSULTANT** REFERRED ME ☐ MY **INSURANCE COMPANY** REFERRED ME	☐ WORD OF MOUTH **RECOMMENDATION** ☐ FOUND **WEBSITE** VIA SEARCH ENGINE ☐ SAW **FACEBOOK** PAGE ☐ PASSING BY/ SAW **SIGNAGE** ☐ I AM A **RETURNING** PATIENT ☐ A MEDICAL PROFESSIONAL RECOMMENDED

CANCELLATION OF APPOINTMENTS

- The Physio Studio respectfully requests that if possible, **24 hours notice** is given if appointments need to be re-scheduled or cancelled to give us the best chance of offering the slot to others.
- A non-attendance **fee of 100%** of the cost of **missed appointments** may be charged if you do not attend a scheduled appointment, or cancel or re-schedule any appointment with less than **24 hours notice.**
- Please note that **insurance companies do not** cover fees for missed appointments and we **cannot** recover these costs from them, so this will be your responsibility.

DATA PROTECTION

- I give consent for my **medical records & client details** to be stored electronically in accordance with the latest **GDPR legislation** using our Private Practice Software (PPS by Rushcliff).
- I understand that by providing my mobile phone number & or email address I am **consenting** to receiving helpful appointment confirmations and follow-up reminders to enable more effective communication.
- I understand that The Physio Studio releases **relevant information** to allow claims to be settled or communicate with 3rd parties on my behalf to aid my further treatment.

BILLING & PAYMENTS (all patients)		
MY PAYMENTS	☐ SELF PAY	
	☐ HEALTH INSURANCE	Please add health insurance details below:

- I understand that the payment of all fees remains my **sole responsibility**
- I understand that all necessary measures will be taken by The Physio Studio to recover any outstanding payments

HEALTH INSURANCE TERMS & CONDITIONS (only if applicable)			
Health Insurance Provider Name		Number Of Sessions Authorised	
Policy Reference Number		Authorisation / Claim Reference Number	

- **I am responsible for all payments** not covered in full or declined by my insurer. This could be due to the membership allowances / benefits, policy excess, a fee shortfall or fee difference on my policy.
- I understand that I need to **know** and **keep track** of the number of **sessions authorised** under my **benefit allowances** to stay within policy limits. Any sessions not covered by my policy are my responsibility.
- I understand that I need to provide my **membership number** and **authorisation / claim reference number before** treatment starts.
- I am aware that if I don't have my policy details on the first appointment then **retrospectively claim funds back** from my insurer directly myself, some insurance companies will **not reimburse** our full self pay rate charged at The Physio Studio.

GENERAL PHYSIOTHERAPY CONSENT (all patients)

- **I understand** that physiotherapy treatment may involve bodily contact, direct / indirect touch
- I understand that **3 months** after my last contact with The Physio Studio I may be discharged. Further treatment after this period **may** need a **full re-assessment** as things may have changed, at the discretion of the therapist.

BY SIGNING, I UNDERSTAND AND AGREE TO ALL OF THE ABOVE.

PRINT PATIENT NAME _____DATE_____

PARENT/ GUARDIAN (if under 16)_____ SIGNATURE_____

Please turn over & continue overleaf…

THE PHYSIO STUDIO

YOUR GENERAL HEALTH AND WELLBEING	
NAME:	**Date of Birth:** / /

Have you RECENTLY noted any of the following? (please tick (✓) ALL that apply, IF ANY)					
Changes in **bladder/ bowel** habit		Regular episodes of **pain at night**		**Fainting** or **blackouts**	
Noticeable **weight loss** or **gain**		Loss in **appetite**		Difficulty keeping **balance**	
Shortness of **breath** on exertion		Increasing **weakness** or **fatigue**		Episodes of **nausea** or **vomiting**	
Fever / chills / night sweats on a regular basis		**Headaches / dizziness / tingling / pins and needles / numbness**		Difficulty **swallowing / visual disturbances / tinnitus**	

GENERAL MEDICAL HISTORY	**YES**	**NO**
Medications: Please make your clinician aware of any medications which may affect your treatment below:		
Do you have any other known **allergies?** ie LATEX (used in medical gloves, nuts)?		
Is there any possibility you are **pregnant?**		
Do you have **diabetes?**		
Have you had any **surgery** which may affect your treatment?		
Do you have a known **ongoing** health condition for which you see a **doctor** about frequently?		
Have you been diagnosed with any **Rheumatoid** conditions?		
Do you have any **metalwork** or **scars** on your body? *pins, plates, joint replacements or piercings?*		
Have you been told you have problems with **bone density**/ thin or weak bones or **osteoporosis**?		
Do you **bruise** easily or take any **blood thinning** drugs?		
Do you have a **pacemaker?**		
Do you have any problems with your **heart or circulation**? *i.e. heart attack, blood clots or stroke?*		
Do you have any problems with your **breathing, chest or lungs**?		

SIGNED_____ DATE_____

PARENT/ GUARDIAN (if under 16)_____

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Please could you fill out the 2 sections below.
This information helps us to monitor your treatment outcomes and maintain quality standards using standardised outcome measures

1. FUNCTIONAL ACTIVITIES SCORE (PSFS Patient specific Functional Scale)

Please identify 3 activities (ie. sport/ leisure, walking, sitting, any tasks etc) that are important to you that you are unable to do or are having difficulty with because of your current injury or problem then **write below and score out of 10** in the boxes using the scale 0-10.

0 1 2 3 4 5 6 7 8 9 10

Unable to perform activity at all → Able to perform activity at the same level as before the injury

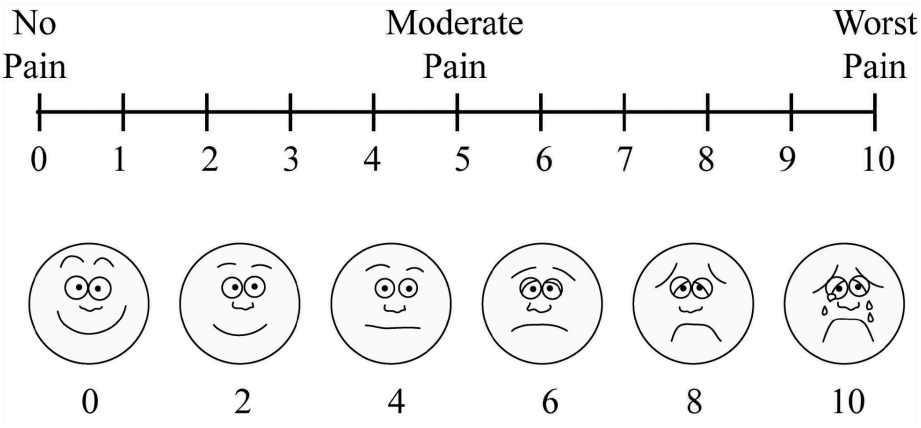
ACTIVITY 1 _____ SCORE 1 ☐ out of 10 today

ACTIVITY 2 _____ SCORE 2 ☐ out of 10 today

ACTIVITY 3 _____ SCORE 3 ☐ out of 10 today

2. PAIN SCALE (Visual analogues scale)

Please use the scale below to tell us about the level of **pain** you are experiencing **today**



INJURY / BODY AREA 1 _____ SCORE ☐ out of 10 today

INJURY / BODY AREA 2
(2nd area only if applicable) _____ SCORE ☐ out of 10 today

SIGNED_____ DATE_____

PARENT/ GUARDIAN (if under 16)_____