|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Please complete using block capitals:** | | | | | | | | | |
| **Title** |  | | | **Home** | |  | | |
| **Surname** |  | | | **Work** | |  | | | |
| **Forename** |  | | | **Mobile** | |  | | | |
| **DOB** |  | | | **Email** | |  | | | |
| **Address** |  | | | **GP Address** | |  | | | |
| **Postcode** |  | | | **GP Name** | |  | | | |
| **Who recommended the clinic to you? Please specify name where possible:** | | | | | | | | | |
| Physiofit reputation | |  | Consultant: | |  | | Relative: |  | |
| Website | |  | GP: | |  | | Friend: |  | |
| Internet search engine | |  | Gym/Pilates Instructor: | |  | | Other |  | |
| Alderleyedge.com | |  | Another physio: | |  | | Signs outside |  | |
| Sports club (which one?) | |  | Education evening (please state where) | | | | | | |

|  |  |
| --- | --- |
| Pt ID |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How do you wish to pay for your treatment? Please tick. Appointments cancelled with less than 12 hours’ notice will be charged at 50% of the treatment rate. (A message can be left on our answer phone.)** | | | | | | |
| **Cash** |  | **Card** |  | **Cheque** |  | All treatments to be paid for on the day |
| **Insurance company** | | |  | | | It is the patient’s responsibility to obtain and complete forms/referral requirements prior to commencing treatment. Should the insurer not settle the bill within 12 weeks it is the patient’s responsibility for making the payment. |
| **Membership no** | | |  | | |
| **Claim no** | | |  | | |

**Medical Check List: Have you had any of the following conditions? If so, please tick the appropriate box and give details to your physiotherapist**.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Epilepsy |  | Bladder or bowel problems | |  | Heart condition or Pacemaker |  |
| Cancer |  | Headaches | |  | Car accident |  |
| Diabetes |  | Blood Pressure | |  | Dizziness |  |
| Operations |  | Allergies (inc latex) | |  | Asthma |  |
| List any current medication taken: | | | | | | |
| Have you ever taken steroids? | | | Have you ever taken anticoagulants? | | | |

|  |  |
| --- | --- |
| F I consent to being assessed | YES/NO |
| I consent to a treatment summary being sent to my GP/Consultant/Health Insurance | YES/NO |
| I consent for my e-mail address to be used for appointment reminders/exercise programmes | YES/NO |
| I would like to receive the Physiofit monthly newsletter | YES/NO |
| I consent for photo/video material to be taken and held securely by Physiofit Ltd | YES/NO |
| I have read and understood this form and confirm the information I have given is accurate | YES/NO |
| I have read and understood the Physiofit Privacy Policy and agree to the terms laid out | YES/NO |

**Signed:**  **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient/Parent or Guardian if u18:**