

FROAT RUNNER

PHYSIO | PILATES | COACHING

NEW CLIENT REGISTRATION FORM

Today's Date:		Title: <input type="checkbox"/> Miss. <input type="checkbox"/> Ms. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	
PATIENT INFORMATION			
Patient's last name:	First Name:	Male <input type="checkbox"/>	Female <input type="checkbox"/>
		Birth date (DD/MM/YYYY):	
Street Address:		Suburb:	Postcode:
Occupation:	Home phone:		Mobile
Hobbies/ Sports/ Physical Activity:	Are you an Athletics WA/ Triathlon WA/ WA Marathon Club Member? <input type="checkbox"/> YES <input type="checkbox"/> NO		
OTHER INFORMATION			
<ul style="list-style-type: none"> How did you find out about this practice? <ul style="list-style-type: none"> <input type="checkbox"/> Facebook <input type="checkbox"/> Website <input type="checkbox"/> Family/ Friend <input type="checkbox"/> Close to home/ work <input type="checkbox"/> Referred by another Practitioner <input type="checkbox"/> Front Runner Sports <input type="checkbox"/> The Running Centre <input type="checkbox"/> Other: _____ Name of Referrer: _____ Do you have Private Health Insurance? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, Health Fund name & number: _____ What is your preference form of communication? <input type="checkbox"/> SMS <input type="checkbox"/> Email Point of contact to inform of treatment plan (Coach, Doctor, etc...) <ul style="list-style-type: none"> Name: _____ Number: _____ Email Address: _____ What is the reason for seeking our services today? _____ What are your short term goals to achieve from physiotherapy/ our services, what time frame? _____ Do you also have long term goals? _____ Will this consultation be a Work Cover Claim? <input type="checkbox"/> YES <input type="checkbox"/> NO <ul style="list-style-type: none"> Claims Manager _____ Claim No. _____ Which Insurance Company will the claim be lodged with? _____ 			
IN CASE OF EMERGENCY			
Name of local friend or relative:	Relationship to patient:	Home phone no:	Work phone no.:
			Mobile no.
Medical Alerts			

Lakeside
Unit 2/ 182-184 Harborne St
WEMBLEY 6014

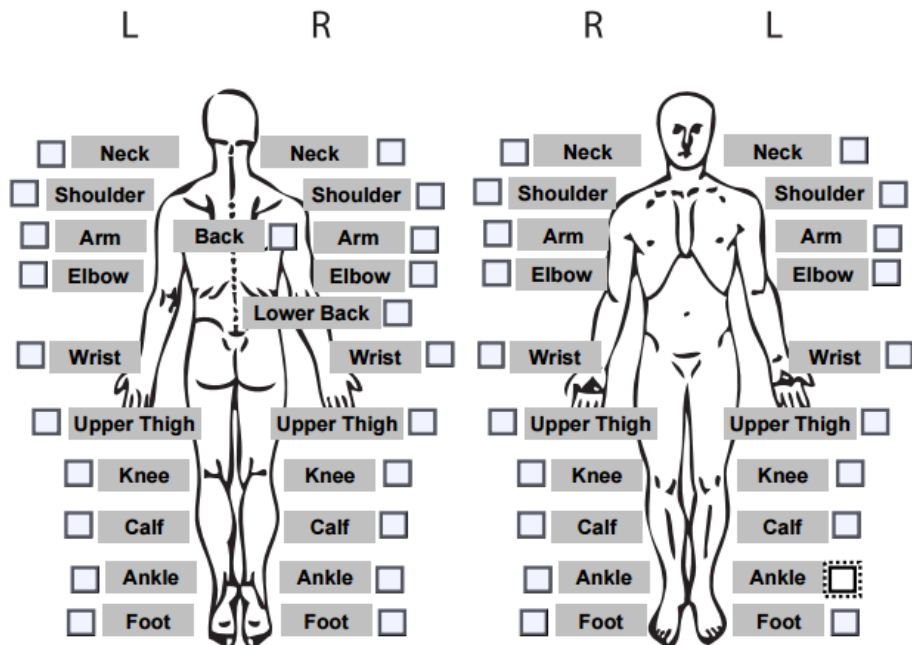
West Perth
1273 Hay Street
WEST PERTH 6005

Phone: 0478 841 104
Website: <http://fronrunnersports.com.au/physiotherapy>
ABN: 76990763914

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Draw on the sketch below, the area where you feel your problem to be.



OTHER

Please list the area you would like treated below

How long have you had this problem? _____

Have you had this or a similar problem in the past? _____

If you are experiencing pain, please tick the words that best describe your pain:

<input type="checkbox"/> Constant Intensity	<input type="checkbox"/> Varies	<input type="checkbox"/> Sharp	<input type="checkbox"/> Travels
<input type="checkbox"/> Comes and Goes	<input type="checkbox"/> Radiates	<input type="checkbox"/> Intensity Doesn't Vary	<input type="checkbox"/> N/A

Do you get?

<input type="checkbox"/> Pins & Needles	<input type="checkbox"/> Tingling	<input type="checkbox"/> Numbness	<input type="checkbox"/> Weakness	<input type="checkbox"/> Other
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Since the problem started, is it:

<input type="checkbox"/> About the Same	<input type="checkbox"/> Getting Better	<input type="checkbox"/> Getting Worse
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Which activities make your pain worse?

<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing Up	<input type="checkbox"/> Walking	<input type="checkbox"/> Running	<input type="checkbox"/> Other:
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Other health professionals seen for this problem (please tick & name):

<input type="checkbox"/> Medical Doctor	<input type="checkbox"/> Specialist	<input type="checkbox"/> Surgeon	<input type="checkbox"/> Massage Therapist
<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Physiotherapist	<input type="checkbox"/> Other	<input type="checkbox"/> N/A

• Name: _____

Do you have or have ever had? (tick any that are relevant)

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- | | | |
|--|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Bladder or Bowel Difficulty | <input type="checkbox"/> Ankylosing Spondylitis | <input type="checkbox"/> Dislocations |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psoriatic Arthritis | <input type="checkbox"/> Ligament Injuries |
| <input type="checkbox"/> Strokes | <input type="checkbox"/> Reiter's Arthritis | <input type="checkbox"/> Cartilage Injuries |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> A Pacemaker | <input type="checkbox"/> Spinal Trauma | <input type="checkbox"/> Unexpected Weight-Loss |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Spinal Fracture | <input type="checkbox"/> Taken Steroids/Oral cortisone/prednisolone |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Spinal Surgery | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Recent Nausea/Feeling unwell | |

Details: _____

CLINIC POLICY

PRIVATE HEALTH COVER REBATES

All Physiotherapy, Dietitian, Group Class appointments are delivered by qualified health professionals – therefore you have the ability to claim back with your private health care if you have cover. All Group Class sessions are performed with a trained Physiotherapist or Exercise Physiologist.

CANCELLATION/ MISSED APPOINTMENTS

If you are running late, it would be greatly appreciated if you can call ahead and let us know. As we need to keep time for all booked appointments, this may mean that you will have shortened treatment time, or we can provide you with a later time that may be available.

- For non-attendance for group classes without notice of at least 6 business hours, you will be charged one class fee.
- For non-attendance for other appointments without notice of at least 24 hours, you may incur a cancellation fee.

RECOVERY

Remember that healing and recovery takes time and not everyone heals/recovers at the same rate. If at any time during your care, you do not feel that you are responding as well as expected, please discuss this with your physio. We want you to get the most from your care at Active Physiotherapy Mackay.

REFERRALS

The greatest compliment we can receive is the referral of a friend or family member. We look forward to assisting you and trust that your experience here is a positive one.

APPOINTMENT SCHEDULING

Your physiotherapist will outline a recommended action plan as the best plan for your injury. You will achieve the maximum results when you keep your recommended action plan to this schedule. To receive the most out of your care, and to save time, we ask that you schedule your appointments when receiving your plan or at your appointment (bookings available on [ONLINE](#))

CORRESPONDENCE

Our physiotherapists will contact your nominated Doctor/ Coach/ Medical Professional to inform them of your progress. At Front Runner Physiotherapy we believe in building a team of health care professionals to best achieve your health goals. Your signature below indicates that you give permission to the therapist to exchange information with your Doctor, Coach, Allied Health Practitioners, Medical Specialists, Lawyers, and third party (insurance/Workcover) Case Managers, when necessary. This information will be confidential. I consent to Active utilising technology including clinical photography/videography, with careful storage of my images

TREATMENT CONSENT

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Physiotherapy treatment is an effective and safe form of treatment however like any treatment there are benefits and risks. Physiotherapists in this practice will discuss your condition and options for treatment with you so that you are appropriately informed and can make decisions relating to treatment. You may choose to consent or refuse any form of treatment for any reason including religious or personal grounds. Typical physiotherapy carries a remote possibility of injury to structures such as but not limited to; nerves, bones, muscles, ligaments, discs or arteries. Physiotherapy can occasionally cause local swelling, bruising or transient increases in pain or other symptoms. Electro-physical agents such as ultrasound or interferential therapy have been linked to minor burns and abnormal skin reactions. Allergic skin reactions to creams, tape, or needles are a possibility. You will be asked to expose the injured body part for assessment and treatment. Please inform your physiotherapist if you feel uncomfortable at any time, as alternative methods are available.

Your physiotherapist may ask personal questions relating to your injury and how your injury impacts on your 'activities of daily living'. The more information you provide, the more likely it is that the physiotherapist can provide effective treatment. If you feel uncomfortable with a particular question please let the physiotherapist know. You have the right to a second opinion at any time. The large array of skills in our team allows this to occur easily. Please contact your physiotherapist immediately if you experience adverse reactions. It is important to attend follow-up appointments as arranged by your physiotherapist to allow completion of your course of planned treatment

POLICY

The above information is true and accurate to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Front Runner Physiotherapy or insurance company to release any information required to process my claims. I consent to Front Runner Physiotherapy obtaining and giving information, both verbally and in writing, to/from other Health Professionals pertaining to the medical conditions, where relevant, to the treatment being received Front Runner Physiotherapy. These professionals may include your Sports Doctor, GP, Case Manager, Radiologist. Etc

I, the undersigned, consent to treatment from health professionals at Front Runner Sports / The Body Station Physiotherapy. Any expenses, costs or disbursements incurred by Front Runner Physiotherapy / The Body Station Physiotherapy in recovery of outstanding monies including debt collection fees and Solicitors costs shall be paid by me, the undersigned. I agree that the account is incurred as a result of treatment and is ultimately my responsibility. In absence of a third party accepting responsibility for payment of my account, I agree to pay for any costs incurred.

PAYMENT IS REQUESTED AT TIME OF SERVICE. WE ACCEPT CASH, CREDIT CARDS AND EFTPOS!

Client Name (Please Print): _____ Date: _____

Client Signature (or Guardian): _____

The above must be at least 18 years of age, otherwise consent from a guardian or parent is required to treat a minor.

- Please tick this box to confirm that you have read and give consent to Front Runner Physiotherapy Clinic Policy.
- Please tick this box if you wish to NOT receive information, news, educational videos from Front Runner Physiotherapy

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