SYNERGY HEALTHWORKS

Patient Details

TITLE:_____ SURNAME:_____

GIVEN NAMES:_____ PREFERRED NAME: _____

ADDRESS:_____ SUBURB:_____

STATE:_____ POSTCODE:_____ D.O.B._____ OCCUPATION:_____

MOBILE PHONE:_____ HOME/WORK PHONE:_____

EMAIL:_____

HOW WOULD YOU LIKE TO RECEIVE YOUR APPOINTMENT REMINDERS? EMAIL ☐ SMS ☐

EMERGENCY CONTACT NAME:_____ PHONE NUMBER:_____

LOCAL DOCTOR:_____

DO YOU HAVE PRIVATE HEALTH INSURANCE? YES ☐ NO ☐ NAME OF INSURER:_____

DO YOU CONSENT TO YOUR PRACTITIONER CORRESPONDING WITH YOUR DR / REFERRER? YES ☐ NO ☐

WOULD YOU LIKE TO RECEIVE THE SYNERGY HEALTHWORKS NEWSLETTER VIA EMAIL? YES ☐ NO ☐

HOW DID YOU HEAR ABOUT SYNERGY HEALTHWORKS?_____

FOR WORKERS COMPENSATION / COMPULSORY THIRD PARTY PATIENTS / DVA

EMPLOYER'S NAME & ADDRESS:_____

CONTACT NAME:_____ PHONE:_____ FAX:_____

INSURANCE COMPANY:_____

ADDRESS:_____

CASE MANAGER:_____ PHONE:_____ FAX:_____

CLAIM NUMBER:_____ DATE OF INJURY:_____

CONTRACT

I HEREBY CONFIRM THAT THE DETAILS ABOVE, TO THE BEST OF MY KNOWLEDGE, ARE TRUE AND CORRECT.
I AM AWARE OF AND AGREE TO THE FOLLOWING:

- I AM FINANCIALLY RESPONSIBLE FOR ALL CONSULTATIONS AND ASSOCIATED COSTS, EVEN IN THE EVENT THAT MY WORKERS COMPENSATION, COMPULSORY THIRD PARTY, MEDICARE OR DVA CLAIM IS REJECTED.
- ACCOUNTS ARE TO BE SETTLED AT THE TIME OF CONSULTATION
- PATIENTS MAY BE CHARGED A CANCELLATION FEE OF $50 IF THEY CANCEL WITHIN 24 HOURS OF THEIR APPOINTMENT.
- MY PRACTITIONER MAY REPLY TO AN EMAIL ENQUIRY FROM ME VIA AN EMAIL RESPONSE.

NAME:_____ SIGNATURE:_____ DATE:_____

SYNERGY HEALTHWORKS New Injury Sheet

1. **Injury Details**

Presenting Complaint:_____

How long have you had this complaint?_____

Have you had this complaint before?_____

Previous treatment: _____

Have you had any scans? _____

2. **Medical History**

Last medical check up: _____Regular doctors name: _____

Specialist: _____other health care provider: _____

Have you had any major injuries (eg broken bones/torn tendon/muscle/ligaments/cartilage)

Yes/No Details: _____

Have you had any major surgeries? **Yes/No** Details: _____

_____

Please tick if you have ever had or been any of the following:

☐ Asthma/lung conditions	☐ pain/chest tightness	☐high blood pressure
☐High cholesterol	☐rheumatic fever	☐ any heart condition
☐stroke	☐dizziness	☐Diabetes
☐stomach ulcer	☐Liver/kidney condition	☐ hernia
☐Circulation problems	☐Thyroid condition	☐Tuberculosis
☐Epilepsy	☐ Cancer	☐Prolonged steroid use
☐Pregnant	☐Osteoarthritis/joint pain	☐Rheumatoid arthritis
☐Osteoporosis	☐Osteopenia	☐Haemophillia/HIV, Hep A/B/C)
☐Heart disease		

Are you taking any medications: **Yes/No** please list: _____

_____

3. **Physiotherapy Goals**

- Have you been to a physiotherapist before? _____
- What would you like to achieve from physiotherapy? _____
- What is your main goal of physiotherapy? _____

4. **Client Rights**

- You have the right to request a further opinion, to refuse treatment or to see a different physiotherapist. If you require access to your client records, they will be provided to you at reasonable and necessary cost.

Patient/Representative Name: _____Signature: _____Date: _____

Practitioner Name: _____Signature: _____Date:_____