



## In-Line Physio & Allied Health 'Client Information Form'

Mr/ Mrs/Miss/Ms/Master (First) Name: \_\_\_\_\_ Surname: \_\_\_\_\_

Contact No: Mobile \_\_\_\_\_ Home No \_\_\_\_\_

Email Address: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_ Post Code: \_\_\_\_\_

Occupation: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_

Do you have Referral DVA, Work Cover, EPC or CTP Insurance Claim? Y / N: \_\_\_\_\_

GP Name: \_\_\_\_\_ Suburb: \_\_\_\_\_ GP Phone No: \_\_\_\_\_

Do you have any allergies? Y / N Give details: \_\_\_\_\_

Do you have pacemaker / other implants? Y / N \_\_\_\_\_

Have you had surgery within the past 12 months? Y / N please give details \_\_\_\_\_

Current Medication: \_\_\_\_\_

Medical History: \_\_\_\_\_

### CONSENT FORM

Your consent is required to provide treatment &/or service, retain your information on our data base and share (if necessary) with your referring GP or Medical Practitioner for the purpose of reporting on your condition after your assessment and/or treatment.

I, \_\_\_\_\_ (Full Name) give my consent to provide treatment &/or service and retain information provided in this form for the purpose as stated below.

Could you please TICK the boxes below giving your CONSENT to the different treatments In-Line Physio offers:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Physiotherapy           | <input type="checkbox"/> Spinal Manipulation       | <input type="checkbox"/> Remedial Massage        |
| <input type="checkbox"/> Clinical Pilates / Yoga | <input type="checkbox"/> Acupuncture /Dry Needling | <input type="checkbox"/> Nutritionist/Naturopath |

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_