Elite Sports Physiotherapy

Mezzanine Level
13–15/1 Freshwater Place
Southbank VIC 3006
P: 8640 0328
W: www.elitesportsphysio.com.au
E: info@elitesportsphysio.com.au

Patient Registration

Please complete all pages in block letters. Not sure of an answer? Leave it blank and your physiotherapist will go through it with you.

1 YOUR DETAILS

Title: ☐ Mr ☐ Ms ☐ Mrs ☐ Miss ☐ Mx ☐ Dr ☐ Master

First name(s) _____ Surname _____

Preferred name _____ Date of birth _____

Home address _____

Suburb _____ State _____ Postcode _____

Mobile _____ Email _____

Occupation _____ Sports / main activity _____

2 EMERGENCY CONTACT

Emergency contact _____ Relationship _____ Phone _____

3 HEALTH COVER & CLAIMS

Do you have private health insurance with Extras cover? ☐ No ☐ Yes Fund _____

Is your treatment being claimed through any of these? (tick one)

☐ No, none of these ☐ WorkCover ☐ TAC ☐ DVA ☐ Medicare (GP Chronic Condition Management Plan)

If you ticked WorkCover, TAC, DVA or Medicare, please also complete:

Medicare number (if applicable) _____ DVA card / number (if applicable) _____

Claim / file number _____ Date of injury / accident _____

Insurer / agent _____ Employer (WorkCover) _____

Claim manager / contact _____ Phone _____

Important: Please refer to the billing information in your welcome pack, as you may have out-of-pocket costs.

4 HOW DID YOU HEAR ABOUT US?

☐ Google search ☐ Friend / word of mouth ☐ Doctor's referral

☐ Signage ☐ Brochure / flyer ☐ Social media

☐ Local gym: _____ ☐ Workplace: _____ ☐ Other: _____

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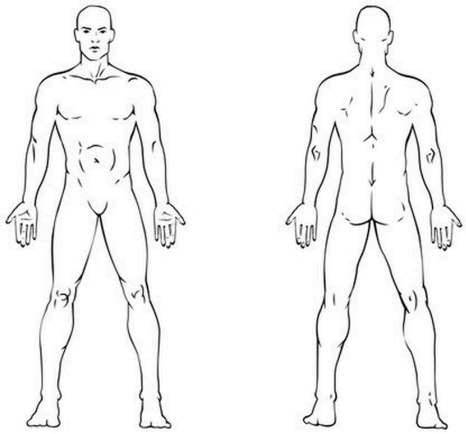
Your Health History

1 WHERE ARE YOUR SYMPTOMS?



Please annotate or shade the areas where you feel symptoms. You can mark the type of symptom using these descriptors:

//// Sharp pain
···· Dull ache
∞ Pins & needles
×× Numbness
~~ Burning, hot or cold feeling
W Weakness / loss of power

2 ABOUT YOUR PROBLEM

What is your main problem? _____

How and when did it start? _____

Have you had this, or something similar, before? When? _____

Any scans, X-rays or other treatment for it so far? _____

How would you describe your pain? (tick all that apply)

☐ Constant ☐ Comes and goes ☐ Aching ☐ Sharp ☐ Shooting ☐ Radiating ☐ Tightness
☐ Varies in intensity ☐ Other: _____

Pain at its worst (circle: 0 = none, 10 = worst)

0 1 2 3 4 5 6 7 8 9 10

Pain right now (circle: 0 = none, 10 = worst)

0 1 2 3 4 5 6 7 8 9 10

What makes it worse?

_____

_____

_____

What makes it better?

_____

_____

_____

3 GENERAL HEALTH

Medications you currently take _____

Allergies (incl. medications, tape, latex) _____

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General Health & Consent

3 GENERAL HEALTH (CONTINUED)

Do any of these apply to you now, or in the past? (tick all that apply)

- ☐ Heart problems
- ☐ High / low blood pressure
- ☐ Pacemaker
- ☐ Aneurysm
- ☐ Stroke / brain injury
- ☐ Fainting / dizzy spells
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Diabetes
- ☐ Cancer
- ☐ Unexplained weight loss
- ☐ Blood thinners
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Spinal fracture
- ☐ Psoriasis
- ☐ Steroid use
- ☐ Contagious disease
- ☐ Bloodborne disease
- ☐ Recreational drug use
- ☐ Recent surgery

Details of anything ticked, or other conditions _____

Are you pregnant, or could you be? ☐ No ☐ Yes ☐ Not applicable How many weeks? _____

4 HOW WE CONTACT YOU

We handle your information in line with the Australian Privacy Principles.

- We will send you appointment reminders by SMS, and receipts by email.
- We may send a report or update about your treatment to your GP or referring doctor.
- We may share relevant information with your insurer or claim manager (WorkCover, TAC, DVA or Medicare claims only).

1. Consent to assessment and treatment

I understand my physiotherapist will assess my condition and explain their findings, the proposed treatment, any alternatives, and the likely benefits and risks. I understand assessment and treatment may involve hands-on techniques that may cause discomfort.

I can ask questions, decline any part of treatment, or withdraw my consent at any time.

2. Payment and cancellation terms

I have read the *Payments & Policies* page in my information pack and agree that:

- Payment is due at the time of each consultation
- If I cancel within 4 hours of my appointment, or don't attend, I will be charged the full consultation fee
- For WorkCover & TAC claims, I understand there may be out-of-pocket costs that will require payment at the time of consultation. For Medicare billings, payment in full will be required at the time of consultation. We will process the rebate, which will be returned to your bank account.

DECLARATION

I confirm the information I have provided is correct to the best of my knowledge. I agree to the terms above.

Patient or guardian signature _____ Date _____