Active Physiotherapy Katherine

Ph. 08 8971 2505

Patient Name:_____

Address:_____

Work phone: _____Home: _____ Mobile: _____

DOB:_____ Occupation:_____

Email: _____

(*We are sending regular newsletters informing you of upcoming specials - you can opt out any time)

Next of kin/emergency contact:_____

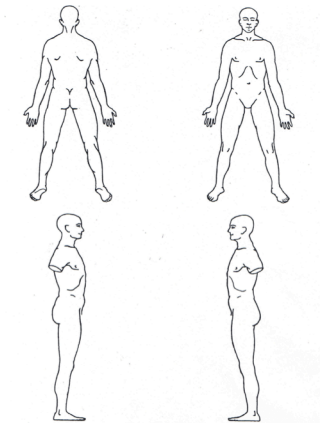
☐ Private Health Fund ☐ Medicare/EPC ☐ No insurance ☐ DVA

☐ Workcover Claim No._____ ☐ others _____

Referring Doctor:_____

Area of pain:_____

On the line provided, please mark where your 'pain status' is today.



_____

No pain Most severe pain

Where did you hear about Active Physiotherapy:

☐ GP/specialist _____ ☐ Yellow pages ☐ Facebook ☐ internet search/ webpage

☐ Friend/Family, name:_____ ☐ living local/sign ☐ other_____

MISSED APPOINTMENT POLICY- PLEASE READ AND INITIAL

Please note that 24 hours notice must be given if you have to change or cancel your appointment. Failure to do so or if you fail to attend an appointment without any notice, the full treatment fee will be charged. Please note, cancellation fees are not covered by a third party and must be paid by the patient.

Please initial _____

I hereby authorise and grant permission to the treating Physiotherapist to carry out any assessment and examination, procedures, and treatments as may be necessary to assess and treat my condition or injury.

Date _____ Signature _____