KINFOLK
PHYSIOTHERAPY AND WELLNESS

Name:	Date of Birth:
Address: Post Code:	Phone: Email:
Occupation:	How did you hear about us:
GP:	Other health professionals you work with:
Emergency Contact (Name):	Emergency Contact (Phone):

Please indicate any wellness modalities you may be interested in:

- ☐ Dry Needling
- ☐ Chinese Medicine/Acupuncture
- ☐ Pilates
- ☐ Running Assessment
- ☐ Massage
- ☐ Nutrition

Your main goal for today's session? _____

My priorities for therapy:

- ☐ Pain relief
- ☐ Obtaining an accurate diagnosis
- ☐ Massage
- ☐ Home exercises
- ☐ Improved flexibility
- ☐ Miracle cure

General Medical History - *please check all that apply*

High blood pressure	☐	Diabetes	☐
Low Blood pressure	☐	Epilepsy	☐
		Osteoporosis	☐
Angina	☐	History of cancer	☐
Anaemia	☐	Kidney problems	☐
Bruising/bleeding issues	☐	Lung problems	☐
Blood clots	☐	Asthma	☐
Chills/fevers	☐	Sinus	☐
Falls	☐	Neurological conditions	☐
Inflammatory bowel	☐	Depression	☐
Constipation	☐	Anxiety	☐
Diarrhea	☐		
Food sensitivities	☐	Sudden weight loss/gain	☐
Excessive fatigue	☐	Increased symptoms with cough	
Changes in bowel or bladder function	☐	or sneeze	☐
Urinary infections	☐		
Pacemaker	☐	Antibiotics (past 6 months)	☐
History of surgery	☐	Steroid use	☐
Latex sensitivity	☐	Pregnant	☐

Medications (+ any known side effects):
Allergies:

Practice Information and Consent Form

- Payment is requested at the time of service.
- A 24 hour cancellation notice is required if you are unable to attend the session.
- If there is no given notice, full payment will apply at the next session.
- If you are running late, the session will be shortened so that the next client is not inconvenienced.

By Signing This Form

- I consent *Kinfolk Physiotherapy and Wellness* to obtain and release information, both verbally and in writing, to/from other health professionals e.g. GP, Specialist Doctor, Radiologist etc. pertaining to the relevant medical condition.
- I understand that achieving the best outcome is a collaboration between myself and my health care team.
- I understand I am ultimately responsible for my health and I will cooperate with treatment and attend all scheduled appointments, unless unusual circumstances arise. I understand that I may be discharged from physiotherapy if I fail to make my appointments without calling to reschedule.
- I will participate in home exercises the therapist has given, and if there are any problems or difficulty I will discuss with the therapist.
- I understand there is no guarantee of a cure, but the physiotherapist will share all of his/her knowledge about my condition including statistics and prognosis.
- Occasionally there will be treatment soreness as a result of the physiotherapy interventions and will generally subside within 48 hours. The physiotherapist will explain what to do to in this circumstance.
- Physiotherapy involves touch during assessment and treatment. Your privacy and modesty will be respected through appropriate use of towels. If you feel at all uncomfortable, please let you physiotherapist know.
- All physiotherapy treatment options will be explained to me and alternatives to physiotherapy may be offered if applicable.
- After having the risks and benefits explained to me by my physiotherapist, I consent to treatment.

Appointment reminders via: ☐ Email ☐ SMS Text Message

Participant's Name	**Participant's Signature**	**Date**