ADVANCED PHYSIOTHERAPY CENTRES Ltd
REGISTRATION FORM

Please note all information provided will be treated as strictly confidential and will not be passed on to third parties. As part of our quality assurance policy we would like to be able to contact you after completion of your course of treatment in order to assess long term outcomes (e.g. that you remain pain-free one year after physiotherapy treatment) and also to notify you of any changes to our services.
Please tick box if you do not want to be contacted. ☐

Your Details

Title: Mr / Mrs / Miss / Ms / Other:		
Surname:	Forenames:	**Contact Numbers:**
Date of Birth:	Age:	Home:
Home Address:		
		Work:
		Mobile:
Email:		
Next of Kin Name:		Relationship to you:
Contact No:		
GP Details Name:		Tel No:
Address:		

PRIVATE MEDICAL INSURANCE DETAILS:(Please complete this section if you intend to claim physiotherapy fees through Private Medical Insurance)

PMI Company:
Policy Number:
Registration/Authorisation Number:
Other Info:
Please check details of your PMI policy. Please note that we are not responsible for any non-payment of claims.

REFERRAL SOURCE: Word of Mouth / Onsite advertising / Web search / Passed by / GP / Consultant /Trainer/ Other:

CONSENT:
Physiotherapy is a safe and effective form of treatment for musculoskeletal disorders when applied by Chartered Physiotherapists. With certain techniques used in physiotherapy practice a small element of risk is present and you may experience some side effects from treatment. Your Physiotherapist will explain the potential benefits, risks and side effects from the treatment options available to you in order to allow you to make an informed decision. Please sign below to indicate your consent in principle for physiotherapy and that you have read our Consent for Physiotherapy Assessment and Treatment Information Document.

Signed: Date:

CANCELLATION POLICY

Please note that a discretional 100% cancellation charge will apply if you fail to give **24 hours notice** of cancellation or if you fail to attend an appointment

DECLARATION:

I, the undersigned, acknowledge and agree to full and final responsibility for the settlement of my accounts notwithstanding any agreement to settle my accounts by a third party. I understand that I will be charged a discretional 100% cancellation fee if I fail to give **24 hours notice** or fail to attend an appointment.

Signed: Date:

GENERAL HEALTH(Please circle your response)		
1.	Are you currently feeling fit and well?	Yes No
2.	Are you running a temperature at present?	Yes No
3.	Have you had any illnesses in the last 3 weeks (e.g. cold, flu, infections etc)?	Yes No
4.	Do you tend to contract colds and flu frequently?	Yes No
5.	Have you experienced any nausea, vomiting or diarrhoea recently?	Yes No
6.	Have you noticed any swelling, lumps or thickening anywhere on your body?	Yes No
7.	Do you have any unhealed sores anywhere on your body?	Yes No
8.	Have you experienced any unexplained weight gain or loss recently?	Yes No
9.	Have you experienced any unexplained sweating recently?	Yes No
10.	Do you experience episodes of dizziness or fainting?	Yes No
11.	Do you currently smoke?	Yes No
	If yes indicate number per day _____ No of years you have smoked _____	
12.	Do you drink alcohol?	Yes No
	If yes indicate number of units per week _____	
13.	Do you have a pacemaker or transplanted organ?	Yes No
14.	Do you have any metal implants or joint replacements?	Yes No
15.	Have you had any scans or X-rays recently?	Yes No
16.	Have you had any blood tests or urine tests recently?	Yes No
17.	Do you experience any problems with concentration, short/long-term memory, attention or decision making?	Yes No
18.	Have you had any stressful events in your life recently?	Yes No
19.	How much caffeine do you consume daily (tea, coffee, chocolate, soft drinks)?	

Response Number (Please leave this box blank for therapist)	Detail

Drug History		
1.	Are you taking any prescribed or over-the-counter medications at present? If yes please give details below:	Yes No
2.	Have you ever been prescribed with steroids or blood-thinning medication? If yes please give details below:	Yes No
3.	Do you use recreational drugs? If yes please give details below:	Yes No
Trauma / Surgery history:		
1.	Have you ever sustained any major injuries in the past? If yes please give details below:	Yes No
2.	Have you undergone surgery in the past? If yes please give details below:	Yes No

PERSONAL / FAMILY MEDICAL HISTORY: Please indicate if either you or any immediate family member (parents / siblings only) have been diagnosed with any of the following medical conditions (Please circle your response)

1.	Cancer	**25.**	Emphysema
2.	Diabetes	**26.**	Tuberculosis
3.	Hypoglycaemia (low blood sugar)	**27.**	Migraine / Headaches
4.	Hypertension (high blood pressure)	**28.**	Anaemia
5.	Hypotension (low blood pressure)	**29.**	Ulcers / stomach problems
6.	High Cholesterol/Hyperlipidaemia	**30.**	Bowel Disorders: Diverticulitis, Chrons Disease, Irritable Bowel Syndrome, Celiac Disease
7.	Cardiac disease	**31.**	Depression
8.	Angina or chest pain	**32.**	Anxiety / panic disorder
9.	Shortness of breath	**33.**	Other psychiatric conditions: Schizophrenia, Bipolar Disorder. ADD/ADHD/ PTSD
10.	Stroke	**34.**	Body Image Disorders/Eating Disorders
11.	Kidney disease / stones	**35.**	Learning Difficulties
12.	Peripheral Vascular Disease	**36.**	Chemical dependency (alcohol, drugs)
13.	Urinary tract infection	**37.**	Gout
14.	Allergies	**38.**	Haemophilia / slow healing
15.	Asthma / hay fever	**39.**	Guillain-Barre syndrome
16.	Rheumatic / scarlet fever	**40.**	Epilepsy
17.	Osteoarthritis	**41.**	Thyroid problems
18.	Rheumatoid arthritis	**42.**	Multiple sclerosis
19.	Lupus	**43.**	Fibromyalgia
20.	Hepatitis / jaundice	**44.**	Osteoporosis / osteopenia
21.	Liver disease / cirrhosis	**45.**	Ankylosing Spondylitis
22.	Polio	**46.**	Parkinson's
23.	Chronic bronchitis	**47.**	Motor Neuron Disease
24.	Pneumonia	**48.**	Myalgic Encephalitis (ME)/Chronic Fatigue Syndrome
		49.	Other

Response Number	Detail (Please leave blank for Therapist)

Female Patients only:

1. Are you pregnant or actively trying for a pregnancy currently?	Yes No
2. Do you have any biological children?	Yes No
a. If yes please give year(s) of birth(s) and means of delivery ie. Vaginal or C-Section.	
3. Do you have any menopausal symptoms?	Yes No

WORK HISTORY

1.	What is your current occupation? (write 'student' if you are in full-time education): Please indicate how many months / years you have worked in this occupation:	
2.	Have you had any time off work as a result of the problem you are attending physiotherapy for?	Yes No
	a. If yes, how long have you been off work? And when are you expected back to work?	
	b. Do you think you will recover from this injury and return to work?	Yes No
	c. Are you on light duties or reduced hours at present?	Yes No
3.	Do you experience any of the following in your workplace (tick all that apply):	
	a. High pressure in terms of time/workload d. Mundane Work	
	b. Low job control e. Lack of support from co-workers/management	
	c. Job Dissatisfaction f. Bullying/harrassment	
4.	Does your job involve prolonged sitting?	Yes No
	If so have you had a work station assessment?	Yes No
	If so have the recommended changes been implemented?	Yes No
5.	Have you had your eyes tested in the last two years?	Yes No
6.	Does your job involve lifting, bending, twisting, climbing, working at extremes of temperature or exposure to chemicals?(please circle relevant)	

Response No:	Detail

EXERCISE & SPORT HISTORY/CURRENT LEVEL OF FITNESS

Please list the physical activities, exercise and sports you perform regularly:

Activity (i.e. Housework, DIY/Gardening, sports, keep fit, play with dependent children, walking)	Duration (i.e. length of time you exercise for each episode)	Intensity (i.e. how hard you are working whilst performing the exercise)	Frequency (i.e. how often do you perform this type of exercise?)	Current ability to perform this exercise (i.e. Unrestricted / partially restricted / Fully restricted)

GOALS

What are you hoping to achieve by attending physiotherapy? (tick all that apply):

- Fully resolve my current complaint(s)
- Enable me to effectively self-manage my condition(s)
- Prevent a relapse of my condition(s) in future
- Return to work
- Return to sport/activity:_____

When do you need to achieve your goal(s) by:_____

Therapist Name: **Signature:** **Date:**

ACUPUNCTURE CONSENT FORM

A variety of acupuncture techniques are practiced at our clinics. These include Traditional Chinese needling and Western acupuncture techniques including periosteal, trigger point and Gunn-IMS acupuncture. Acupuncture involves the insertion of single-use, sterile, disposable acupuncture needles into various musculoskeletal body parts in order to release stimulate natural healing processes. Acupuncture is generally very safe however as acupuncture is an invasive procedure there are some potential risks and side effects. These range from relatively common but not serious side effects to more serious but very rare side effects.

Serious and rare side effects include: infection, organ puncture (i.e. punctured lung) and seizure (fitting). The risk of serious adverse events arising in association with acupuncture is estimated at 0.05 per 10,000 treatments and 0.55 per 10,000 individual patients i.e. very low risk and below that of many common medical procedures (White, 2004). If serious side effects do arise as a result of acupuncture and if these are not managed appropriately then the consequences could lead to permanent disability or even death. To put this risk in context however in two UK surveys no serious adverse events were reported in more than 66,000 acupuncture treatments given by 652 acupuncturists in various health professions (White 2006). In addition to this finding two surveys of acupuncture safety among regulated, qualified practitioners in Germany confirm that serious adverse events after acupuncture are uncommon. Indeed when the findings of the UK and German surveys are combined there were no deaths or permanent disabilities arising from over three million acupuncture treatments; furthermore all patients who did experience adverse events fully recovered (Xu, 2013).

Less serious but more common side effects include: drowsiness / tiredness (3% of consultations, White 2006), minor bleeding / bruising (3% of consultations, White 2006), worsening of existing symptoms (2% of consultations, White 2006), pain at insertion site of needle (1% of consultations, White 2006), fainting (<1% of consultations, White 2006), nausea or vomiting (<1% of consultations, White 2006).

Acupuncture is generally not recommended in patients with unstable angina, unstable asthma, active lung disease (emphysema), epilepsy or haemophilia. Acupuncture can be used with caution on immunosuppressed patients and those receiving anticoagulation therapy (warfarin / heparin). Acupuncture is best avoided if you are feeling unwell, have not eaten or if you have an important function to attend after your session. It is advisable to avoid driving or operating machinery immediately following acupuncture treatment.

The acupuncture procedure used in this clinic adheres to the Acupuncture Association of Chartered Physiotherapists Code of Practice i.e. only sterile, disposable needles are used by appropriately qualified practitioners.

Statement of consent:

The purpose, benefits and potential risks of acupuncture treatment have been explained to me. I confirm that I have read and understood the above information and I consent to having acupuncture treatment. I understand that I can refuse treatment at any time.

Patient / Legal Representative Signature: (Status if applicable):

Patient Name: Dated:

Physiotherapist Signature: Dated:

References:

1. White A. A cumulative review of the range and incidence of significant adverse events associated with acupuncture. Acupuncture in Medicine 2004; 22(3):122-133.
2. White A. The safety of acupuncture – evidence from the UK. Acupuncture in Medicine 2006; 24 (Suppl): S53-57.
3. Xu S. et al. Adverse Events of Acupuncture: A Systematic Review of case reports. Evidenced Based Complementary and Alternative Medicine. Volume 2013 (2013), Article ID 581203, 15 pages http://dx.doi.org/10.1155/2013/581203.

SPINAL MANIPULATION CONSENT FORM

Spinal manipulation techniques are used in this practice in order to restore optimal movement of stiff joints and thus relieve any associated pain and muscle spasm. Manipulation involves the passive movement of joints by the therapist and is often associated with an audible 'pop' or 'click' coming from the joint or surrounding joints undergoing treatment. Our therapists have undergone extensive training in these techniques. Spinal Manipulation might be indicated as part of a package of treatment aimed at restoring optimal movement of other joints such as the knee or shoulder in addition to treatment for spinal problems directly. Manipulation does not form an essential part of our treatment programmes but can be a useful adjunct.

Manipulation is generally very safe however as in all areas of medicine there are some potential risks and side effects. These range from relatively common but not serious side effects to more serious but very rare side effects.

Serious risks and side effects associated with spinal manipulation include: death; stroke; permanent nerve damage (i.e. loss of sensation and / or loss of power); loss of use of limb(s) i.e. tetraplegia and paraplegia; vertebral fractures; and embolic events (i.e. damage to major blood vessels with potentially life-threatening consequences). The risk of serious adverse events arising with manipulation is not known but estimates range between 1 in 20,000 and 1 in 4 million treatments (Robson, 2003) i.e. a very low risk.

Certain manipulative techniques are thought to have a greater associated risk than others therefore such techniques are not applied in this clinic. The majority of serious adverse effects associated with manipulation appear to have arisen when the techniques have been applied inappropriately e.g. in patients with back pain caused by spinal tumours or spinal infections, in patients with osteoporosis, in patients on long-term steroid or anticoagulant medication, in patients with neurological deficits due to compression of nerves in the spine and in patients with neck pain and/or headaches due to pre-existing problems with the blood vessels in the neck. **To avoid inappropriate application of manipulation please ensure you have filled in your medical history forms accurately.**

Less serious but more common side effects include dizziness, exacerbation of existing symptoms and post-treatment soreness**.**

Manipulation is best avoided if you are feeling unwell, have not eaten or if you have an important function to attend after your session.

Statement of consent:

The purpose, benefits and potential risks of spinal manipulation have been explained to me.

I confirm that I have read and understood the above information and I consent to having spinal manipulation. I understand that I can refuse treatment at any time.

Patient / Legal Representative signature:

Status (if applicable):

Name: Dated:

Physiotherapist: Dated:

References:

1. Robson S. Manipulation – An Evidence Based Perspective. PPA News 2003; (issue 16): 12-17.