CARBERY PHYSIOTHERAPY

Patient Name: ____

Address: ____

D.O.B. ______________________

Contact No: ________________________e mail______________________

Club: ______________________________

GP: ______________________________Occupation:______________________

Diagnosis and reason for referral:

____
____
____

When did the symptoms start? ____

Are the symptoms worsening? ____

Relevant medical History:

____
____
____

Is the patient on anticoagulants, steroids, opiates medication or any medication that would alter treatment?____
____
____

PRECAUTIONS: PLEASE STATE YES OR NO:

Allergies ____________________________________

Pace maker ____________________________________

Blood pressure issues ____________________________

Osteoporosis __________________________________

Pregnancy____________________________________

Is there any recent investigation that may affect treatment?

Please include results of x rays, CT scans, MRI scans.

A text reminder will be sent if we have a mobile number and **24 Hour notice of cancellation required.**

Do you consent to a report of your physiotherapy assessment to be faxed to you GP for their records? **Yes/No**

Our privacy statement is displayed on desk and notice board for your information.

Consent to Treatment **Yes / No** **Consent to Acupuncture** **Yes / No**

Signature ______________________________ **Date** ______________________________

www.carberyphysiotherapy.ie *Contact No. (086) 8049526*