Client Information Form

Client Details:

Full Name	
Preffered Name	
Date of Birth	
Phone	
Email	
Address	
Occupation	

Emergency Contact details:

Name	
Relationship to you	
Phone	

Health care details:

Medicare Card Number	
Medicare Reference Number	
Doctor's Name	
Doctor's Address	
Doctor's Phone	
Private Health provider	

Do any of the following referrals apply:

- Team care arrangement referral from GP
- Work cover claim
- Motor Vehicle accident claim
- DVA referral
- NDIS plan

If so please provide details including claim numbers

Your current health situation:

What brings you to us? _____

What are your goals for physiotherapy?

_____

_____

Do you suffer from, or have you suffered from any of the following? If Yes please provide details

Fractures	
Surgery	
Dizziness	
Regular headaches/migraines	
Neurological event (stroke/TIA)	
Diabetes	
Heart problems	
High/Low blood pressure	
Epliepsy	
Osteoporosis	
Arthritis	
Cancer	
Autoimmune conditions	

Do you have any allergies? ☐ No ☐ Yes, please list

_____

Are you or could you be pregnant? ☐ No ☐ Yes, due date: _____

Are you taking any regular medications? ☐ No ☐ Yes, please list

_____

_____

Declaration

I declare the information provided is correct to the best of my knowledge. I accept and agree to Swell Life physio's Privacy policy and terms and conditions. I consent to treatment by the physiotherapist, and understand I can ask questions or decline treatment at any time.

Client/ guardian signature: _____

Date: _____