hobsonville physiotherapy
MOVEMENT FOR LIFE

Welcome to Hobsonville Physiotherapy,

- proudly supporting Hobsonville Podiatry & Hobsonville Massage.

Thank you for choosing us as your healthcare provider and for giving us the privilege of helping you to achieve your health goals. You're taking the first step towards resolving your condition, improving your function your overall health. We've successfully helped thousands of people and look forward to the opportunity to help you.

We've prepared this information so you'll know what to expect during your initial consultation. You'll soon meet your therapist after filling out some paperwork describing you, your health history and your health goals.

Your therapist will discuss your problem to fully understand your issue during the initial assessment. This examination is thorough and includes testing all possible contributing factors for your condition including muscle/joint/nerve/bone/thoughts/feelings etc.

The purpose of your initial assessment consultation is to form a treatment plan and decide the most rapid and complete solution possible with a thorough, individual approach.

Your role is to actively participate in this process, to learn the significant factors that contribute to your pain/injury condition, and to discover what is required to most rapidly fix your condition.

In a small percentage of cases a Plan B may be the most appropriate management, for example an alternative treatment approach, X-ray or referral to another health care provider. We will ensure to do this as soon as this is indicated.

Finally, the majority of our clients are self-referred or through word of mouth. They come to see us because they are pleased with what we've achieved for them in the past or because they have family and friends who were so pleased with our service they've sent others to us. We would be delighted to receive referrals from you if you are happy with our service as this is the greatest compliment.

Please complete the attached forms as this will assist us to focus on your issue and speed up your initial consult. If you have any questions or concerns please don't hesitate to ask your therapist or the reception staff.

Yours Sincerely

The Hobsonville Physiotherapy Health Team

hobsonville physiotherapy
MOVEMENT FOR LIFE

+Physiotherapy
+ Podiatry +Sports Medicine
+ Remedial & Sports Massage+
Rehabilitation +Acupuncture +
Biomechanics

Personal Information

Mr ☐ Mrs ☐ Miss ☐ Dr ☐

Click here to enter text.	Click here to enter text.	Click here to enter a date.
First Name	Last Name	Date of Birth
Click here to enter text.	Click here to enter text.	
Address		
Click here to enter text.	Click here to enter text.	
Email	Occupation	
Insert number	Insert number	Insert number
Phone M	Phone H	Phone W

If you **DO NOT** wish to receive helpful information regarding health care, injury prevention and specials on product, please tick ☐

The following information is to assist with completeness in the assessment process. The information is used in accordance with the Privacy Act. Please answer all appropriate sections to the best of your ability. If you have any cultural issues we should be made aware of please advise your physiotherapist prior to treatment.
Copies of the Code of Health and Disability Services Consumer Rights and Responsibilities

Click here to enter text.	Yes ☐ No ☐
Area of concern eg neck, knee etc	Have you had previous treatment for this injury?

Are you currently **Suffering from any of the following**

Pins and needles	☐	Vomiting	☐
Constant Pain	☐	Weakness	☐
Light Headedness	☐	Sharp Burning Pain	☐
Nausea	☐	Tinnitus	☐
Numbness	☐	Headaches	☐
Night Pain	☐	Other: here to enter text.	
Dizziness	☐	Other: Click here to enter text.	

Have you **Suffered from any of the following**

Cancer	☐	AIDS / HIV	☐
Hepatitis	☐	Broken Bones	☐
Heart Disease	☐	Asthma	☐
Diabetes	☐	Diabetes	☐
Anxiety / Depression	☐	Other: Click here to enter text.	

List any Medications you are currently taking: Click here to enter text.

General Health Questions continued

Please check the answer boxes Yes or No

1. Is your general health good? Yes ☐ No ☐

   If no, please specify: Click here to enter text.

2. Is there any chance that you are pregnant? Yes ☐ No ☐
3. Have you had recent scans or other medical investigations including blood tests? Yes ☐ No ☐
4. Have you experienced any unexplained weight loss? Yes ☐ No ☐

Who is your usual Doctor: Click here to enter text. Clinic: Click here to enter text.

Pre attendance Information: Accelerate your treatment by helping us understand your problem

- This information can save you up to 15minutes as we would prefer to plan your case prior to your first consultation
- Please take time to carefully consider the questions as this will assist treatment focus. Try to be as specific as possible.

Presenting Problem(s). List in order of importance: Click here to enter text.
What is your main problem that you would be most satisfied if fixed first?: Click here to enter text.
What is the main function that this problem limits (e.g. Rotating neck while driving?) Click here to enter text.
What would you consider a 'good result' from your treatment? Click here to enter text.
Is there any other information that you would like us to know that is relevant Click here to enter text.

Contacts to assist your recovery

Your recovery can be enhanced when significant others can support your recovery. With your permission your therapist may ask to contact people in your support network to share appropriate information on your treatment and results. Examples may include: Partner, Coach, GP, Employer, Friend etc.

Name Click here to enter text. Phone: Insert number email: Click here to enter text.

Name Click here to enter text. Phone: Insert number email: Click here to enter text.

How did you find us ?

Doctor referral ☐ Road Sign ☐ Word of Mouth ☐ Name of referrer: Click here to enter text.
Previous patient ☐ Editorials / articles which one: Click here to enter text.
Directories ☐ which one: Click here to enter text. Web page ☐

Cancellation Policy

Your appointment time is reserved and dedicated to focus on you. It prevents anyone else from booking an appointment in your time. Please allow a **minimum of 4 hours notice** or if your appointment is in the morning, the day before. Failure to notify us will result in **being charged a full fee**.

1. I hereby consent to the treatment provided by Hobsonville Physiotherapy once it has been adequately explained and jointly agreed upon. I understand that I have the right to refuse treatment at any time.

2. I understand that I am responsible for the cost of my treatment whether or not that cost is Private, covered by ACC, a Medical Insurance company, or third party.

3. I understand that should I wish to cancel an appointment I should give 4 hours' notice otherwise I will incur a cancellation fee.

4. If your injury is sustained as a result of an accident, I understand that a partial payment for my treatment may be paid for by ACC once my claim has been approved. I also understand I will be liable for a co-payment for each consultation covered by ACC.

5. I the undersigned, hereby declare that I have read and understood the Terms and Conditions. I also certify that all the information above is true and correct.

Please print your full name: Click here to enter text.

Signature of client: Date: Click here to enter a date.

(sign in clinic)

Signature of client's parent/guardian if client under 16: Date: Click here to enter a date.

(sign in clinic)