Please print and bring this form with you to your appointment or send to [info@feingoldphysio.com.au](mailto:info@feingoldphysio.com.au).

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| **Personal Information** | |
| Name: Name | DOB: ­Date of Birth |
| Address: Street Address | Phone: Phone Number |
| Suburb: Suburb and Postcode | |
| Email: Email | |

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| **Insurance Information** | |
| Medicare No: Medicare Number Ref No: Ref No Expiry: Exp Date | |
| Private Health Ins: Company Name Only | DVA No: Veterans Only |
| Is your visit related to a motor vehicle accident or workplace injury? Y/N (Please fill in claim details on pg2) | |

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| **Medical Information** | | | |
| Doctor/GP: Doctor/GP Practice: GP Practice/Suburb | | | |
| Are you seeing a Specialist for the area being treated? Y/N | | | |
| Name: Specialist Practice: Specialist Practice/Suburb | | | |
| How did you hear about our practice: Click here to enter text | | | |
| Do you have any history of the following: Mark all that apply | | | |
| Arthritis  Bursitis  Sciatica  Scoliosis  Joint Swelling | Headaches  Lower Back Pain  Neck Pain  Pins & Needles in Limbs  Pain waking at night | Vision/Hearing Problems  Balance/Falls  Jaw Problems  Irritable Bowel  Cancer: | Respiratory Problems (e.g. asthma, chronic cough, shortness of breath)  Genitourinary Problems (e.g. frequent urination, incontinence) |
| List of Medications: Medications | | | |
| Previous Surgeries: Medical History - Surgeries | | | |

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| **Primary Condition** |
| Main Area to be treated: ­Main Area to be treated |
| Main Symptoms: Main Symptoms |
| How long have you had this issue: How long – Days/Months/Years |
| Is this a recurrence? Y/N If yes, when did it last happen: Last occurence |

**Cancellation Policy:**

**Please call us on (02) 9569 3330 by 3:00 p.m. on the day prior to your scheduled appointment** to notify us of any changes or cancellations. If prior notification is not given, you may be charged a cancellation fee for the missed appointment. Please sign below to consent to these terms.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

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| **Insurance Claim Details** (Please complete if your appointment will be covered by an insurance claim) |
| Claim No: Claim Number Date of Injury: Date of Injury |
| Insurance Company: Insurance Company Case Manager: Case Manager |
| Contact Details: |
| Email: Case Manager Email |
| Phone: Case Manager Phone Fax: Case Manager Fax |
| Additional Information: Additional Information |