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NECKSBACKSSPORTS
Gentle Effective Care

Welcome to Necks Backs Sports

Please take the time to answer these questions as accurately as possible as this will assist us in providing the best care for you. If you have any questions or concerns, do not hesitate to ask for assistance.

1. Patient Details

Dr / Mr / Mast / Mrs / Ms / Miss / Other: _____ *(circle one)* First Name: _____

Surname: _____ Preferred name: _____

Address: _____

Suburb: _____ Post code: _____

Phone – Home: _____ Phone – Work: _____

Phone – Mobile: _____ Email: _____

- We will use this email for the following purposes: email receipts, exercise sheets and information sheets. We will not disclose your email to any third party. If you do not wish to receive our information sheets, please tick this box □

Date of Birth: ____/ _____/ _____ Occupation: _____

Person to contact in case of emergency: _____

Who can we thank for referring you to our practice: _____

We provide a reminder service 2 days before your appointment.
Please nominate which service you would prefer: *(tick one)* ☐ Sms ☐ Email

- When rescheduling or cancelling an appointment we require 24 hours notice. Whilst we understand things come up, changes at short notice are very disruptive to the clinic. Most importantly, changes at short notice take away the opportunity for someone else to receive our care. Appointments that are rescheduled or cancelled within 24 hours of the appointment will incur a missed appointment fee. Please note, this fee will be waived on presentation of a medical certificate. Missed Appointment fees are not covered by health funds.

2. Medical History

GP's Name: _____ Phone Number: _____
I give permission for my medical practitioner to be contacted: (*signature*) _____

Are you taking any medication? (*tick one*) ☐ Yes ☐ No
Please list: _____

Do you have any allergies? *(tick one)* ☐ Yes ☐ No
If "yes", which one(s)? _____

Is your Blood Pressure usually: *(tick one)* ☐ Low ☐ Normal ☐ High
Last reading: _____ / _____ Date: _____

Have you had any hospital admissions or surgeries? ☐ Yes ☐ No
If "yes", please list, including dates: _____
_____

Have you had any accidents/fractures? ☐ Yes ☐ No
If "yes", please list, including dates: _____
_____

2. Medical History (cont.)

Do you or have you had any of the following symptoms/conditions? (*please tick*)

Heart Disease	☐	Pace Maker	☐	Rheumatic Fever	☐
Stroke	☐				

Name of Heart Specialist _____
Date of last check up with specialist _____
I give permission for my medical practitioner to be contacted: (*signature*) _____

Aids/HIV	☐	Epilepsy	☐	Osteoporosis	☐
Anaemia	☐	Glandular Fever	☐	Pinched Nerve	☐
Arthritis	☐	Glaucoma	☐	Pneumonia	☐
Asthma	☐	Hepatitis	☐	Rheumatoid Arthritis	☐
Cancer	☐	Herniated Disk	☐	Shingles	☐
Chronic Fatigue	☐	High Cholesterol	☐	Thyroid Problems	☐
Depression	☐	Migraine Headaches	☐	Tuberculosis	☐
Diabetes	☐	Multiple Sclerosis	☐		

Female Patients
Are you Pregnant? ☐ Yes ☐ No
What is your due date? _____
Obstetrician's Name: _____ Phone Number: _____
I give permission for my medical practitioner to be contacted: (*signature*) _____
Are you Nursing? ☐ Yes ☐ No

3. Daily Habits

What level of exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy

What types of exercise do you do? _____

Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes per day? _____ or packets? _____

How many standard alcoholic drinks do you consume on a daily basis? _____

How many caffeinated drinks do you consume on a daily basis? _____

4. Symptoms

Reason for Visit: _____

When did you first notice the symptoms? _____

Is the condition getting progressively worse? ☐ Yes ☐ No

What activities are difficult to perform? *(please tick)*

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Stretching ☐Other:_____

Is the pain constant or does it come and go? _____

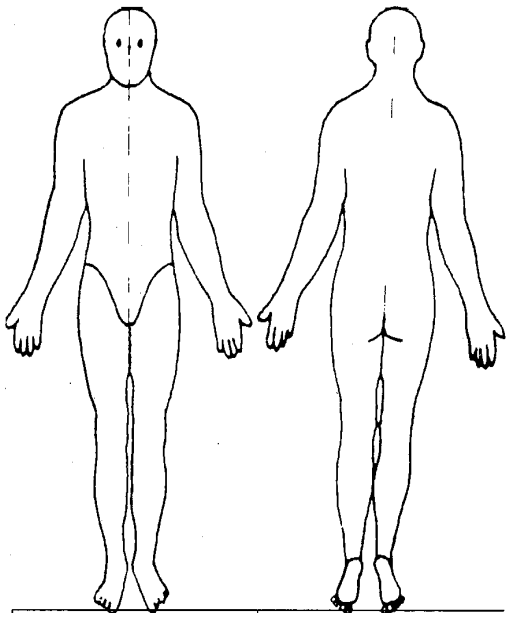
Have you received treatment for your condition? ☐ Yes ☐ No

If "yes", please list: _____

Please rate the severity of your pain (1 = mild pain or discomfort, 10 = severe pain) _____

4. Symptoms (cont.)

Please draw out your pain in the diagram below:



Using the symbols below, please draw the location of ALL pain that you feel – even if it is unrelated to your reasons for contacting us. Please note that it is very common to experience more than one type of pain in one area, therefore, you may need to use 2 or 3 different symbols. (Example: You may have a constant Dull headache, and a sharp pain in the same area when leaning forward. Therefore you would draw both ✔ ✔ (dull pain) and *** (sharp pain) in the one area).

≈≈ ≈≈	Use Squiggles where you feel **NUMBNESS & TINGLING**
//////	Use Lines where you feel **BURNING or ITCHY PAIN**
✔ ✔	Use Ticks where you feel **DULL ACHE or THROBBING**
***	Use Stars where you feel **SHARP PAIN**
++	Use Crosses where you feel **STIFFNESS**
	Use Circles where you feel **SWELLING**

Office Use Only:
Practitioner Notes