Abundant

Physiotherapy/Exercise Physiology Confidential Case History

You can fill this form in electronically as a PDF or print it off as a hard-copy to fill in by hand

Name:_____
Occupation:_____
Is this a WorkCover or TPI Claim? ☐
Do you have a referral from your GP/Doctor? ☐
Medicare No:_____

Date of Birth: _____
Do you have Private Health Insurance? ☐
WC Claim No./TPI Insurer: _____
Do you have a DVA White/Gold Card? ☐
DVA Number:_____

What is your major reason for seeking an appointment?

What are your short-term goals from treatment?

1.	2.

What are your long-term goals?

History – *please do your best to fill in as much as you can, however your clinician will discuss these details with you further.*

Pre-Exercise Medical Screening: ***Do you/have you ever been told by your doctor that you have the following?***

Any Heart Condition? ☐
Any Breathing or Lung Condition? ☐
Diabetes: Type 1 ☐ Type 2 ☐
Chest Pain with exercise? ☐
Stroke/TIA(Trans-ischemic Attack) ☐

Thyroid Condition? ☐
Asthma attacks requiring medical attention in last 12 months? ☐
Blood Sugar/Glucose control issues in last 3 months? ☐
Faintness, Dizziness or loss of balance with exercise? ☐
High Blood Pressure ☐ Blood clots/DVT ☐
Neurological disorder/brain injury ☐

Cancer ☐ *Type*:
Osteoarthritis ☐
Osteoporosis? ☐
Rheumatoid Arthritis? ☐
Steroid/Corticosteroid use or History of use? ☐
Reiter's/Reactive Arthritis ☐
Pregnant? ☐

Are you a smoker or do you have a smoking history? ☐
Other considerations that may make exercise unsafe? ☐
Details:

Current Health Problems & Symptoms *Attach/bring relevant documents and test results*

What have you tried to manage symptoms?

What makes your symptoms better?

What makes your symptoms worse?

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Past Medical History (Date) *Attach/bring relevant documents and test results*

Past Surgical History/Injuries (Date) *Attach/bring relevant documents and test results*

Physical Activity History *Current & past exercise and physical activity habits (Frequency, Type, Duration)*

Psychosocial/supports:

Medications and Supplements (List all prescription and supplements – this does not have to be comprehensive if you have a record/list)

Name (drug name or brand name)	Dosage	Frequency	Date Started (approx)
PAST			

Doctors and Allied Health Professionals involved in your care

Name	Specialty/Reason	Phone/Email	Practice Location

I give permission for communication to be sent to my Doctor/s regarding my treatment as clinically relevant ☐

I certify that the above information supplied, to the best of my knowledge, is true and correct. I also agree that I have read, understood and agree with the informed consent policies / procedures, and provide my express consent to treatment. ☐

Patient signature:	**Clinician Signature:**