KARE | HEALTH CENTRE

Pre-Consultation Questionnaire – Physiotherapist

Full Name: Mr./Mrs./Ms./Miss_____ DOB: _____ Age:_____

Address: _____

Tel (H): _____(W): _____(M): _____

Treatment Details

Reasons for treatment: _____

Type of Health Fund:

□Private Health Fund □Workers Compensation □Motor Vehicle Accident □Medicare/DVA/EPC

Insurance Company: _____Claim/Membership Number: _____

Personal History

What is your occupation? _____

Are you currently pregnant? Y/N

Medical History

Name of your family Doctor:_____

Address of your family Doctor :_____

Are you suffering from, or have a family history of any of the following?

□ Asthma/Breathing Difficulties	□ High blood pressure	□ High cholesterol
□ Angina/Chest Pain	□ Stroke	□ Cancer
□ Bowel/Bladder Incontinence	□ Gout	□ Dizziness
□ Headache/Migraine	□ Blurred Vision	□ Arthritis

List any other previous major health related issues or surgical procedures

Illness	Date/Year
•	
•	

List any current prescribed medications you are taking

Physical Activities

Please circle which activities you participate in

Walking Swimming Aqua Aerobics Gym Running Tennis Other: _____

Referrer Details: If you were referred to KARE Health Centre

Name of Referrer: _____

What is your relation with your referrer? _____

Consent for Treatment

I understand that the information obtained during this Health Assessment is completely confidential and will be stored and analysed on a database by KARE Health in accordance with the Privacy Act and not released to a 3rd party without prior consent. I also understand that the Health Assessment is a limited health screen for the purpose of identifying a number of health risk factors and does not guarantee complete health status. I understand that participation in the health consultations is entirely voluntary and undertaking this activity is done so at my own risk.

Signature: _____Date: _____