FOUNTAIN GATE PHYSIOTHERAPY CLINIC
PATIENT HISTORY SHEET

DATE: _____

PATIENT INFORMATION

NAME: (MR / MRS / MS / MISS)_____

HOME ADDRESS:_____

_____POSTCODE_____

PHONE (HOME):_____(WORK):_____(MOBILE):_____

DATE OF BIRTH:_____OCCUPATION:_____

How did you hear about us? Internet Google Family/Friend Signage

Yellow Pages Yellow Pages Online GP/Specialist

Health Fund Other:_____

REFERRED BY: _____

NEXT OF KIN/EMERGENCY CONTACT

NAME:_____ PHONE:_____

ADDRESS:_____

RELATIONSHIP TO YOU:_____

OTHER PRACTITIONER INFORMATION

GP'S NAME: _____ SPECIALIST:_____

SPORT INVOLVEMENT

TYPE: _____ CLUB/TEAM:_____

COMPETITION/LEVEL: _____

PATIENT CATEGORY (Please circle)

Private Workcover TAC Medicare DVA Comcare

PRIVATE CLIENTS

Do you have a concession or health care card? YES / NO

Number:_____ Expiry Date:_____

Do you have private health insurance? YES / NO

Health insurance company_____

PTO ➔

WORKCOVER/COMCARE PATIENTS

Employer: _____

Address: _____ Phone: _____

Contact name: _____ Date of injury: _____

Has the injury been reported? YES / NO

Insurance Co. (if known): _____

Claim no: _____ Contact: _____

REHABILITATION PROVIDER: _____

TAC PATIENTS

Date of Accident: _____ Have you submitted a claim? YES / NO

Claim no: _____ Contact: _____

TAC patients are liable for the first $564.00 unless their excess has been reached.

Have you reached this excess? YES / NO

VETERANS AFFAIRS PATIENTS

Do you have a D904 doctor's referral form? YES / NO **VX No** _____

ALL PATIENTS

(please circle)

Have you had any of the following?

(All information is strictly confidential)

Diabetes	Epilepsy	Tuberculosis
Skin disorders	Asthma	Allergic reaction to drugs
Osteoporosis	Cancer	Arthritis
Heart ailments	Dizziness	High blood pressure
Excessive bleeding	Blood borne diseases eg. Hepatitis, HIV+	

Any recent operations? _____

(Female only) Are you pregnant? YES ☐ NO ☐ POSSIBLY ☐

Do you have a cardiac pacemaker ☐ metal implants ☐ hearing aid ☐

The above information is correct to my knowledge at the time of signing this form. I acknowledge that in the event of a WorkCover, TAC or Comcare claim pending, that responsibility for my account will be mine if my claim is rejected. I also acknowledge that private accounts are to be paid at the time of consultation unless prior arrangement is made. Where an account is issued to me, I understand that payment is required within 30 days of its receipt and that if I am in default of payment, steps to recover any monies due will be taken thereafter and any costs in relation to same are to be borne by me.

Signed _____