TE ARO PHYSIOTHERAPY & PILATES

CENTRE OF EXCELLENCE

To enable us to provide you with the best possible treatment, facilities and standards of service, please complete the details below and the next page. **Any information provided remains confidential under the terms of the Privacy Act 1993 and requires your permission for its release to a third party.**

Personal Information

Surname: ______________________ First name: ___________________ M/F Birth date: ___/___/_____

Name of parent/guardian *(if appropriate)*:____

Address: ____

Contact Numbers: Hm: ________________ Wk: _________________ Mobile: ______________________

E-mail:______________________________ Occupation: ___________________G.P:__________________

How did you hear about us?

Specialist/GP/ Yellow Pages/ Friend/Colleague/website/other ___________________________________

Medical Information

In order to provide you with the best care, please indicate if any of the following apply to you:

DIABETES: Yes / No

PACEMAKER: Yes / No

HIV POSITIVE: Yes / No

CANCER (CURRENT OR PAST): Yes / No

Are you PREGNANT: Yes / No

HEPATITIS CARRIER: Yes / No

LONGTERM MEDICATION: ____

CHRONIC CONDITION/S: ____

Other health conditions we should be aware of: ____

Do you consent to us writing a discharge note to your GP at the completion of treatment: Yes / No

Payment Policy

Payment of fees is expected on the day of treatment unless prior arrangements have been made.

Any materials supplied and administered are at an additional cost.

Please Note:

In the event that ACC declines your claim, you will be responsible for costs incurred for treatment received and any additional administrative costs.

A cancellation notice of 24 hours is required or a $45 cancellation fee may incur.

Please use the next page to complete registration

Patient Specific Functional Scale (PSFS)

- Can you please identify up to three important activities that you are unable to do or are having difficulty with as a result of your ________________ problem. Today, are there any activities that you are unable to do or having difficulty with because of your ______________ problem?

- Please list those activities in the table below and rate each one according to the scale (from 0 to 10) given here. Write the number for each activity in the filed "Initial consult" in the table.

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Unable to perform activity									Able to perform activity at same level as before injury or problem	

Activity	Initial consult					
1						
2						
3						
4						
5						
Additional						
Additional						

This is a validated and reliable outcome measure that helps us determine your current functional limitations and plan treatment accordingly. We will come back to those activities on a regular basis during the course of treatment to see whether you have improved or need further assistance.

I confirm that the information provided is true and correct to the best of my knowledge.

Signed Patient/Parent/Guardian:_____________________________________ Date: ___/___/________

Upon signing this declaration you also authorise us to release information to our nominated credit agency sufficient to aid in the collection of any outstanding debts owed to Te Aro Physiotherapy Ltd.