

MEND DIAGNOSTIC CONSULTATION – Part One - Client

Welcome to Mend Physiotherapy.

Physiotherapist: _____ **Signature:** _____

This form provides information for the Diagnostic Consultation and should be completed by all clients. (Existing Mend clients do not need to complete the greyed sections, unless details need updating.) If you have any doubts about relevant information please err on the side of caution, provide as much detail as you can and discuss thoroughly with your Physiotherapist.

The information from this form will be assessed together with an examination, the results of which will be reviewed and discussed with you to determine any further actions/referrals/treatments that are recommended or required.

All information provided remains confidential between the client and Mend Physiotherapy and is not shared with any third party.

Consent

I, the client, consent to the assessment and treatment by the above named Physiotherapist. I understand that before any treatment is carried out, a full explanation of the purpose and any risks associated with the treatment will be explained to me. I understand that should I wish to decline any form of assessment or treatment, then I am in my right to do so and I should inform the Physiotherapist of my wishes at the time. By signing below, I agree to these terms.

Signature: _____ **Date:** _____

We routinely contact each patients GP with a report after their initial Diagnostic Consultation and when their Physiotherapy treatment is complete, we believe this is good Clinical Practice. Please indicate by ticking the appropriate box whether you consent for us to do this.

Yes, I consent for Mend Physio to contact my GP with treatment reports.

No, I do not consent for Mend Physio to contact my GP with treatment reports.

Personal Details			
Name			Address
DOB		Age	
Telephone			
Mobile			
Email			GP Name & Address
Where did you hear about Mend Physio?			

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Health and Performance Updates			
Please mark the areas you would wish to receive relevant updates by email and invitations to talks and events.			
Performance Improvement		Physiotherapy Issues and Clinics	
Cycling		Sports injury management	
Running		Sports specific training	
Golf		Musculoskeletal issues and treatment	
Walking & Climbing		Pre and post operative fitness	
Football & Rugby		Back, neck and shoulder pain	
Triathlon		Leg, ankle and foot pain	
Skiing		Pilates (recovery from injury/osteoporosis/well-being)	
Racquet Sports		Ante/Post natal treatment and advice	
Water Sports		Deep tissue massage for recovery	
Other Sports		M.O.T. for computer users	
		How to age healthily	

Activity	
Are you a Bannatynes member?	Existing Bannatynes member <input type="checkbox"/> New Bannatynes member <input type="checkbox"/> Re-joining Bannatynes <input type="checkbox"/> Member of another Gym <input type="checkbox"/> Non Gym Member <input type="checkbox"/> If appropriate please state name of other Gym: _____ _____
How physically active are you?	1 2 3 4 5 6 7 8 9 10 Not active Very active
What are your reasons for joining the Gym?	
Please describe your main physical activities or sports. Include any gym work/group classes you attend.	
Please describe any sports/gym work/classes that you would like to bring into your exercise regime and explain your reasons why.	
Please describe other activities/hobbies that you	

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enjoy.	
Please state your occupation and give a brief description of your duties. (Continue overleaf)	
Do you spend a lot of time driving for work or other reasons?	

Current Condition

Do you have any current medical conditions?	Yes	No
Please describe the current condition(s).		
Please detail any treatment that you have had for this condition(s).		
Have you had any previous medical problems or musculoskeletal injuries? (Please describe and state the treatment that you have had.)		

Medical History (Please provide appropriate detail in the space below)

Are you losing or gaining weight for no reason?	Yes	No
Are you feeling unwell/feverish?	Yes	No
Do you currently have a good appetite?	Yes	No
Is this normal for you?	Yes	No
Have you ever taken steroids?	Yes	No
Have you ever taken anti-coagulants?	Yes	No
Do you have osteoporosis?	Yes	No
Have you had any previous fractures/current fractures you are recovering from?	Yes	No
Does pain ever keep you awake at night?	Yes	No
Are you experiencing a loss of bladder or bowel control, or numbness around your groin or buttocks?	Yes	No
Do you have any pain when you cough or sneeze?	Yes	No
Have you had cancer in the past?	Yes	No
Is there a history of cancer in your family?	Yes	No
Does it take more than 30 minutes to 'get going' in the morning?	Yes	No

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Do you have pain in lots of your joints?	Yes	No
Do you have any known inflammatory conditions? (eg Rheumatoid Arthritis)	Yes	No
Do you have inflammatory bowel disease?	Yes	No
Do you have any skin problems?	Yes	No
Do you suffer from double/blurred vision?	Yes	No
Do you suffer from black outs?	Yes	No
Do you suffer from dizziness?	Yes	No
Do you have difficulty with speech?	Yes	No
Do you have difficulty with swallowing?	Yes	No
When was your last consultation with a Physiotherapist?		

Please mark any of the following that apply to you.

Asthma		Inflamations		High/Low Blood Pressure	
Heart Problems		Epilepsy			
Diabetes		Pregnancy		Contagious Diseases	
Pacemaker		Fatigue			
Surgery		Thyroid		Allergies	

Please provide details for an answer that you ticked “Yes” for from anything related to your Medical History:

Any other relevant information?

Please list your medications:

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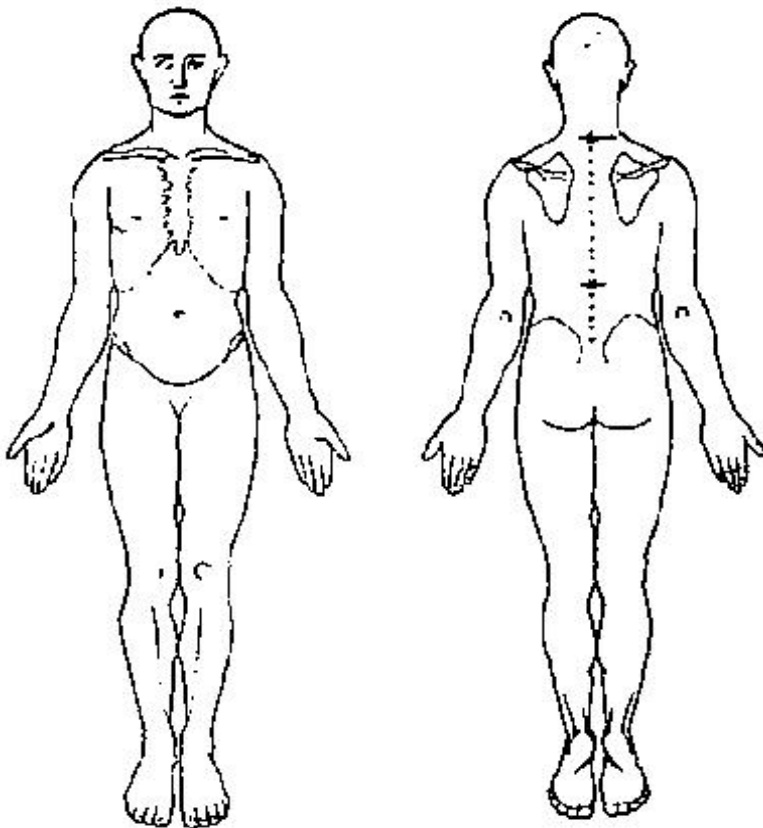
Please mark any areas of pain.

Please mark any areas of tingling/numbness.

Aggravating factors:

Easing factors:

Is there a 24 hr pattern with your pain:



Baseline											
How severe is your pain? (Please circle)	1	2	3	4	5	6	7	8	9	10	
	No Pain							Unbearable Pain			
Are you concerned your pain will never get better?							Yes	No			
Does your pain stop you doing things you enjoy?							Yes	No			
How much do you feel you can change/improve you condition with the right advice?	1	2	3	4	5	6	7	8	9	10	
	Will never improve							Will improve			