

New Patient Form

“Everybody Deserves to Feel Good”



Personal Contact Details		
Miss/Ms/Mrs/Mr/Dr Name:		D.O.B
Address:		Postcode:
Ph: (home)	Ph: (work)	Mob:
Email Address:		
Emergency Contact:		Ph:
Relationship:		
Preferred Contact Method: <input type="checkbox"/> MOBILE <input type="checkbox"/> EMAIL <input type="checkbox"/> HOME PH		
Preferred Appointment Confirmation Method: <input type="checkbox"/> MOBILE <input type="checkbox"/> EMAIL <input type="checkbox"/> HOME PH		

Referral Information		
Private Health Insurance Company:		Fund No#: _____ Line No#: _____
Medicare No#:	Line No#:	
Do you have a referral from your GP? <input type="checkbox"/> YES <input type="checkbox"/> NO		
GP's Name:		GP Clinic Address:
Are you under any of the following? (Please tick)		
<input type="checkbox"/> MEDICARE ENHANCED CARE PLAN <input type="checkbox"/> VETERANS AFFAIRS <input type="checkbox"/> WORKCOVER <input type="checkbox"/> TAC		
Claim No#:		Case Manager:

Knox Leisure Works Member <input type="checkbox"/> YES <input type="checkbox"/> NO	Pensioner <input type="checkbox"/> YES <input type="checkbox"/> NO
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How did you hear about us? (Please tick)		
<input type="checkbox"/> KLW New Member (Boronia)	<input type="checkbox"/> Google	<input type="checkbox"/> Facebook/Social Media
<input type="checkbox"/> Sponsored Sporting Group (see below)	<input type="checkbox"/> Local Paper	<input type="checkbox"/> Gym staff/ PT referral
<input type="checkbox"/> Medical referral	<input type="checkbox"/> Friend/Family referral	<input type="checkbox"/> Walking by the clinic/ A Frame
<input type="checkbox"/> Stay Tuned Newsletter	<input type="checkbox"/> Sign in the gym (Boronia)	<input type="checkbox"/> STSM Webpage
Are you a member of one of the clubs we support? If so which one?		
<input type="checkbox"/> Elsternwick Cricket	<input type="checkbox"/> VicBeach Volleyball	<input type="checkbox"/> Elsternwick Football
<input type="checkbox"/> Mountain District Netball	<input type="checkbox"/> Elwood Soccer	<input type="checkbox"/> Elwood Lawn Bowls
		<input type="checkbox"/> Belgrave South Football
		<input type="checkbox"/> Elwood Cricket

Spinal manipulations may be used by appropriately qualified practitioners where it is appropriate and safe to do so. Manipulations are carried out using minimum force levels in order to maximise safety and minimise patient discomfort. A full assessment is made and all care taken however spinal manipulations have a very small risk of adverse reaction. You will be told if your therapist chooses to use these techniques and asked for your consent each time. Signing below indicates you generally consent to having joint manipulations. You can however choose not to have spinal manipulations at any stage. Please discuss this with your practitioner.

Consent: I give my consent that information regarding my treatment be released to General Practitioner or other referring health practitioner, and/or other Stay Tuned Sports Medicine practitioners as necessary. NB: Psychology files are stored separately in a locked system. I advise staff to call an ambulance if it is required and I agree to meet any expenses attached thereto. **I accept that the full consult fee will apply in cases where 24 hours notice is not given to cancel an appointment or if I fail to attend a scheduled appointment.**

Signed: _____

Office Use Only EP MC SI NPL EE GP Letter

Why are you here today?		
What are your goals of coming in for treatment?		
Are you on any prescribed medication?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Details:
Are you experiencing any pain?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Details:
Have you seen other therapist's before?	<input type="checkbox"/> YES <input type="checkbox"/> NO	What type of therapy did you receive? Did it help? <input type="checkbox"/> YES <input type="checkbox"/> NO

Do you or have you suffered from any of the following? If YES, please provide details in the space below					
1	Joint/Arthritis Problems/Fractures	<input type="checkbox"/> YES <input type="checkbox"/> NO	11	Epilepsy	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	Muscular/Ligament injuries	<input type="checkbox"/> YES <input type="checkbox"/> NO	12	Asthma/Respiratory Problems Shortness of breath \45	<input type="checkbox"/> YES <input type="checkbox"/> NO
3	Lower Back pain	<input type="checkbox"/> YES <input type="checkbox"/> NO	13	Glandular Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO
4	Hernia	<input type="checkbox"/> YES <input type="checkbox"/> NO	14	Faintness/Light headiness/ Blackouts/Headaches/dizziness	<input type="checkbox"/> YES <input type="checkbox"/> NO
5	Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO	15	Vision/ hearing Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
6	Angina/Heart Condition	<input type="checkbox"/> YES <input type="checkbox"/> NO	16	Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO
7	Recent surgery (last 6 months)	<input type="checkbox"/> YES <input type="checkbox"/> NO	17	Any other condition which restricts activity:	<input type="checkbox"/> YES <input type="checkbox"/> NO
8	Regular headaches or migraines	<input type="checkbox"/> YES <input type="checkbox"/> NO	18	Are you a smoker currently? If YES how many per day? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
9	High Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	19	Have you previously been a smoker? When did you start smoking? _____ When did you quit? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
10	Pregnant now or delivered less than six months ago	<input type="checkbox"/> YES <input type="checkbox"/> NO	20	Do you have a family history of any medical conditions?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Details					

We believe "Everybody Deserves to Feel Good", and have a huge range of services to help. If you would like to know more about any of our services please **tick** a box below and we will send you some information.

Please send via Email **or** Postal Mail

Osteo/Physio Nutrition Psychology Podiatry Massage/Myotherapy Weight Loss

Hydrotherapy Stress Pilates Diabetes Yoga (Elwood) Exercise Rehabilitation

Stay Tuned Sports Medicine acknowledges and respects the privacy of individuals. The personal and health information collected is required to determine pre-existing conditions, which may influence the treatment we provide. By completing this form, Stay Tuned Sport Medicine accepts that you, your parents/guardians (if a person under the age of 18) have consented for this information to be collected. The intended recipients of this information are Stay Tuned Sports Medicine, and its authorised staff. You have the right to access and alter personal or health information concerning in accordance with the Commonwealth Privacy Act (Amended 2001) and Stay Tuned Sports Medicine Privacy Policy. You may receive information from time to time regarding our programs and services. Stay Tuned Sports Medicine may also provide promotional material via mail or electronic format. If you do not wish to receive this information please tick the "OPT OUT" box below and return this to Stay Tuned Sports Medicine. Your name will be removed from the mailing list within a reasonable time period.

OPT OUT