Beach Street Centre

Your Health & Wellness Clinic

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& Nutritionist

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Physiotherapy Assessment (Condition > 4 weeks)

By accurately and in detail completing this questionnaire I can make more efficient use of your therapy session. Thank you for your time in filling out the new patient questionnaire. You can leave out any questions if you wish, or write more if you feel there is any other relevant information you need add.

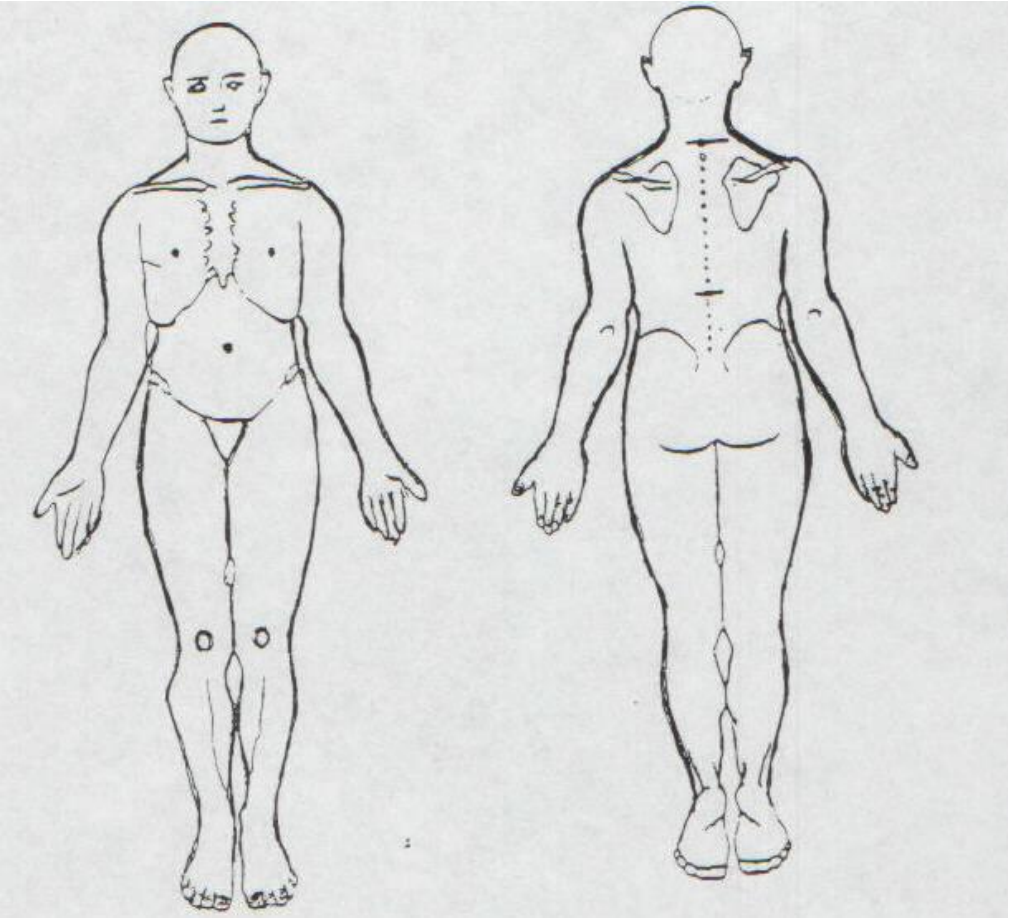
Name:	DOB
Address	
Phone:	Email
If you have a smart phone is it Apple/Android/Microsoft based? (Knowing this helps with providing information on Apps that may help with your Condition)	
Private Health Fund:	No:
Medicare No. (if on a Care Plan)	
Height:	Weight
Today's Date:	

Please provide a brief description of you main reason for this appointment:

On the diagram below mark where you experience your pain with a brief description of its nature (sharp, burning, dull, ache) and a score out of ten (0 is no pain up to 10 as worst pain imaginable?)

If you have different areas of pain identify them separately.

Mark any areas of pins and needles or numbness you experience?



List when you experience each of the above symptoms. If there are 2 or more different symptoms identify when each occurs separately.

Symptom	Activities

Do you experience any of the following (circle)?

Dizziness	Visual Problems	Slurred Speech
Legs collapsing	Problems toileting	Pins/Needles in groin
Uncontrollable Night Pain	Difficulty Swallowing	Nausea/Vomiting

When and how did this condition begin?	
How and when has the condition progressed?	
What treatments have you tried and how have they effected your condition?	
What do you do for work/housework?	
How does this condition affect your work?	
Do your exercise/play any sports?	
How does this condition affect your exercise/sports?	
What hobbies/activities do you enjoy?	

What can you do to relieve your pain including positions, exercise, heat/cold, lotions and potions and medications?

Do you smoke and if so, how many/per day?	
Do you drink alcohol and if so, how many/per day?	
How many serves of caffeine (coffee, energy drinks) per day	

Do you have any issues of weight loss or gain, especially if this injury has persisted?	Yes/No:
Amount of weight loss/gain? Over how long?	
What are your present weight goals, if any?	

How many hours sleep do you get per day? When do you go to sleep and wake up normally? Do you follow a regular pattern of sleep or is it chaotic? Do you have problems with sleep and if so, what are they? What is your usual sleep position? How do you change you sleep position to control the pain? How many pillows do you use?

On average how long do you sit per day?	
On average how long do you stand per day?	
How long are you physically active without specifically exercising?	
Describe a normal exercise/sport week?	
Are you satisfied with the amount of exercise you are doing? If not, what would you like to change?	

Do you do any Relaxation/ Creative Visualisation/Meditation activities in order to improve your condition or life in general?
What Pleasure Activities do you enjoy and what are you Passionate about in life? Have these been effected by your condition?

Is there any other way in which this condition has changed your life that you may wish to discuss and address with treatment (e.g. family relationships etc)?

Have you been Stressed, Anxious or Depressed in the last week (circle which if Yes)?

Have you been Stressed, Anxious or Depressed in the last 6 months (circle which if Yes)?

Are you Stressed, Anxious or Depressed more often than not? (circle which if Yes)?

If you are Stressed, Anxious or Depressed what percentage relates to this condition (mark on line)?

None **50%** **All**

Circle any Medical Conditions that you have or

Box Medical Condition where there is a Family History?

Heart Disease	High Blood Pressure	Low Blood Pressure	Diabetes
Asthma	COPD	Chronic Fatigue	Fibromyalgia
Cancer	Epilepsy	Depression	Anxiety
Osteoarthritis	Rheumatoid Arthritis	PMS	Menopause
Ankyl. Spondylitis	TMJ (Jaw) Problems	Hyperthyroid	SLE
Hypothyroid	Dementia	Alzhiemers Dis.	MS
Osteoporosis	Osteopenia	Mental Health	Incontinence
Irritable Bowel	IBD	Other Gastro (List)	Liver Disease
Psoriasis	Eczema	Lymphedema	Endometriosis
Migraines	Headaches		

Any Other Medical Condition/Surgery?

Do you have any current illness such as cough, cold or flu? Yes/No
Is there any possibility you may be pregnant? Yes/No

List your Current Medication including Nutritional/Herbal Supplements?

In Summary, what treatment approaches do you consider are relevant to your condition?				
	Believe will Help		Willing to Try	
Massage/Manipulation	Yes	No	Yes	No
Exercise and Stretches	Yes	No	Yes	No
Postural Advice appropriate to home, work and sport.	Yes	No	Yes	No
SCENAR	Yes	No	Yes	No
Nutritional Supplementation	Yes	No	Yes	No
Weight Loss	Yes	No	Yes	No
Learning Appropriate Relaxation and Breathing	Yes	No	Yes	No
Help with Sleep	Yes	No	Yes	No
Stress Management	Yes	No	Yes	No
Other Lifestyle Changes	Yes	No	Yes	No
Any ideas of your own you wish to mention or explore?				

Are you prone to fainting or have any fears about any treatment that you may receive (including a fear of needles)?

Do you belong to a local pool or gymnasium and if so, which?

What equipment at home do you have access to exercise?

And finally, and most importantly, write down in detail what will be the most motivating factors in improving your condition and helping you commit to improving this condition?

If you use Nutritional Supplements or would consider using Nutritional Supplements for your Condition complete the following; otherwise you may leave this section.

Nurtitional Supplements Questionnaire (Tick Box for Yes)

Do your regularly miss breakfast?	
Are you a Vegetarian?	
Have you been diagnosed with Fibromyalgia?	
Do you believe you have Chronic Fatigue Syndrome?	

Do you serve more than 3 serves of Fish/week	
Do you find swelling or inflammation persists when you are injured?	
Do you get frequent infections?	

Do you avoid frequent sun exposure?	
Is your pain unrelated to posture of movement?	
Do you get pain in the front of your thighs?	

Do you get muscle spasms and tightness?	
Do you get eyelid twitches?	
Do you crave chocolate?	
Do you get heart palpitations in the absence of Cardiac Disease?	

Do you lack energy?	
Do you feel emotionally exhausted or irritable?	
Do you nod off during the day?	
Can you get overly emotional?	
Do you crave salt?	

Do you get lightheaded or dizzy?	
Do you see spots in front of your eyes?	
Do you avoid red meat?	
Have you ever been anaemic?	

If female, does you pain change with your cycles?	

Do you feel cold much of the time?	
Have you slowly gained weight over the last few years?	
Have you noticed a thinning of your hair and eye brows?	
Do you find it hard to get started in the morning?	

Is your libido lower than you would like?	

Do you experience any of the following Gastrointestinal Symptoms (circle):

Nausea	Flatulence	Diarrhea
Constipation	Pain in Stomach	Pain with Bowels Movements
Reflux	Difficult Digestion	Undigested Food in Stools
Burping	Bloating	