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| **The purpose of this document is to help identify areas of history, lifestyle and activity that may be contributing to your current issue.**  **This helps us find a successful way of working together and allows more time in the consultation to focus on a treatment approach.**  **Please type into the document and send it back. Boxes will expand for more text if required.**  **Feel free to type ‘Y’ or ‘N’ or a full paragraph as you feel. It’s also fine to say you don’t know, or don’t understand the question. That in itself provides me with relevant information.** | |
| Personal details | |
| **Name:** |  |
| **Date of Birth:** |  |
| **Address:** |  |
| **Contact Details:** | **Email:** |
| **Phone:** |
| **How did you hear about Process Physio?** |  |
| Injury details | |
| **What do you believe your issue is and how do you think it happened?**  **Plenty of detail please!** |  |
| **How has this affected your life on a scale of 0 (not at all) to 10 (it's devastating)?** |  |
| **What makes it feel worse?** |  |
| **What makes it feel better?** |  |
| **Do you have any goals/ambitions/trips that may be affected by this injury?** |  |
| **What do you expect/want from Physiotherapy? e.g. how long to recover** |  |

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| More about you | | | |
| **How do you feel most of the time? 0 (worn out) to 10 (fully energised)** |  | | |
| **Have you recently increased your activity levels? If yes please add some detail.** | Yes | | |
| No | | |
| **Has life recently become more busy/stressful? If yes please add some detail.** | Yes | | |
| No | | |
| **How are you sleeping?** | Well | | |
| Average | | |
| Poorly | | |
| **Is this different than normal?** | Yes | | |
| No | | |
| **Do you wake feeling refreshed?** | Yes | | |
| No | | |
| **How is your mental well-being at present?** | Very good | | |
| Good | | |
| Fair | | |
| Poor | | |
| Nutrition - are you fuelling your body for what you want it to do? | | | |
| **Do you have an energy (calories) intake target? If yes please note it.** | | Yes | |
| No | |
| **Do you have a protein intake target? If yes please note it.** | | Yes | |
| No | |
| General health screen  Please supply brief info for any 'yes' answers | | | |
| **Do you regularly achieve the World Health Organisation recommended minimum levels of activity for health:**  **150-300 minutes of moderate, or 75-150 minutes of vigorous, aerobic activity and 2 sessions of moderate to high intensity muscle strengthening activities per week?** | | | Yes |
| No |
| **Do any close family members have the same/similar condition?** | | | Yes |
| No |
| **Do you think you may be or have you been diagnosed as diabetic (type 1 or 2) or pre-diabetic?** | | | Yes |
| No |
| **Do you have, or have you had, asthma or TB?** | | | Yes |
| No |
| **Do you have, or have you had a cancer diagnosis  – or a diagnosis in your close family?** | | | Yes |
| No |
| **Do you/did you smoke?** | | | Yes |
| No |
| **Do you have any heart**  **related issues?** | | | Yes |
| No |
| **Do you have high blood pressure or a history of it in your close family?** | | | Yes |
| No |
| **Are you taking prescribed steroids or have taken them within the last year?** | | | Yes |
| No |
| **Are you taking non-prescribed steroids or have taken them within the last year?** | | | Yes |
| No |
| **Do you have any surgical Implants (knee replacement, internal fixation) or a pacemaker?** | | | Yes |
| No |
| **Have you had any relevant surgeries?** | | | Yes |
| No |
| **Have you had any fractures in/near the affected area?** | | | Yes |
| No |
| **Have you been diagnosed as, or do you think you may be, peri-menopausal, menopausal or post-menopausal?** | | | Yes |
| No |
| **Are you taking any anti-coagulant/blood thinning medications?** | | | Yes |
| No |
| **Current medications:** | | |  |