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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:**   |   |