

# OCCUPATIONAL THERAPY NEW PATIENT REGISTRATION FORM



Title: [Mr/Mrs/Miss/Ms]   Male  Female

Surname:

First Name:

Date of Birth:  /  /

Street Address:

Suburb:  Post Code:

Telephone: Home

Work:

Mobile:

Please provide your email address so we can keep in touch with you.

Email:

Your Dr's Name:

.

Doctor's Address:

Do you give permission for us to send a letter to your Doctor confirming that you have commenced Treatment?

Yes / No

1. How did you find out about this practice?

Advert / Poster  Brochure/ Flyer  Yellow Pages  Yellow Pages Online

Directory Assist  Yellow Pages  Our Website  From My Doctor \_\_\_\_\_

Friend Referral

(name) \_\_\_\_\_

2. In which part of the body is your injury located? \_\_\_\_\_

3. Private Clients :- Do you have Private Health Insurance?(name) \_\_\_\_\_

4. Veterans Affairs Clients :- Card Number \_\_\_\_\_

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5. Do you have a Medicare EPC (Enhanced Primary Care) plan from your doctor? Yes / No

6. Are you claiming through Worker's Compensation or CTP?  Yes [please complete details]

Employer: \_\_\_\_\_ Contact  
Person \_\_\_\_\_

Employers  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Date of  
Injury: \_\_\_\_\_

Insurer: \_\_\_\_\_ Claim No. \_\_\_\_\_ Case  
Manager: \_\_\_\_\_

Insurers  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

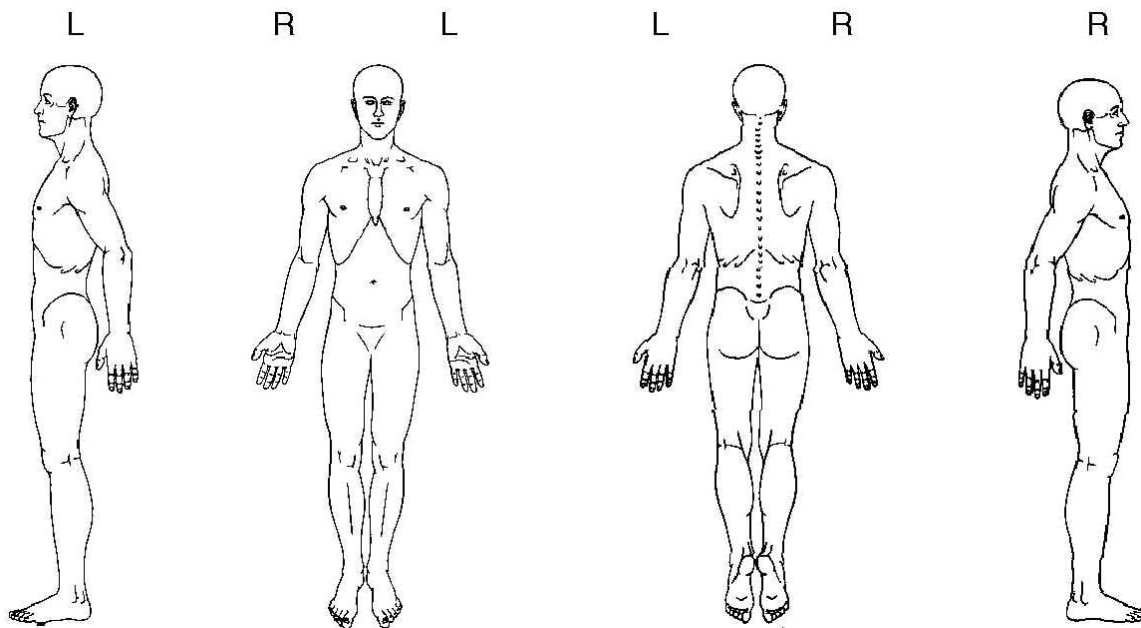
# OCCUPATIONAL THERAPY CONFIDENTIAL PATIENT CASE HISTORY

As An Occupational Therapy practice providing comprehensive care, our goals are:-  
1 - To address the issues that brought you to this practice,  
2 -To treat the cause of your condition (**not just** treat the symptoms or find a temporary solution).  
3 -To offer you the opportunity of improved health potential and wellness services in the future.  
Answering the following questions will give us a profile of your health, and ensure that we optimise your outcome and deliver physiotherapy excellence.

What is the reason for seeking our services today?\_\_\_\_\_

What do you hope to achieve specifically from treatment? (Include goals and deadlines)\_\_\_\_\_

Draw on the sketch below the area where you feel your problem to be.



How long have you had this problem?  
\_\_\_\_\_

Have you had this or a similar problem in the past?  
\_\_\_\_\_

If you are experiencing pain, please tick the words that best describe your pain:

- |   |   |                                       |                                   |                                  |                               |      |
|---|---|---------------------------------------|-----------------------------------|----------------------------------|-------------------------------|------|
| <input type="checkbox"/> Constant         | or  | <input type="checkbox"/> Comes & goes | <input type="checkbox"/> Sharp    | or                               | <input type="checkbox"/> Dull | Achy |
| <input type="checkbox"/> Intensity varies | <input type="checkbox"/> Intensity doesn't vary | <input type="checkbox"/> Shooting     | <input type="checkbox"/> Radiates | <input type="checkbox"/> Travels |                               |      |

Do you get?

- |   |                                   |                                   |                                   |
|---|-----------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pins and needles | <input type="checkbox"/> Tingling | <input type="checkbox"/> Numbness | <input type="checkbox"/> Weakness |
|---|-----------------------------------|-----------------------------------|-----------------------------------|

Since the problem started, it is -

- About the same     Getting better     Getting worse

What makes your pain worse?

- Sitting                       Standing up from a chair                       Walking

Other \_\_\_\_\_

Your pain interferes with:

- Work                       Sleep                       Hobbies                       Leisure

What type of work do you do?

\_\_\_\_\_

Other health professionals seen for this problem (please list):

Medical Doctor \_\_\_\_\_

Specialist Doctor/Surgeon \_\_\_\_\_

Chiropractor \_\_\_\_\_

Other \_\_\_\_\_

List any medications you are taking \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever taken oral cortisone or prednisone (including asthma medications such as pulmicort, symbicort, flixotide & seretide)? Yes / No

Are you pregnant? Yes / No / NA

Do you have or have you ever had?: (please tick)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Spinal fracture    |
| <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Osteoporosis           | <input type="checkbox"/> Spinal surgery     |
| <input type="checkbox"/> Heart problems      | <input type="checkbox"/> Rheumatoid arthritis   | <input type="checkbox"/> Dislocations       |
| <input type="checkbox"/> Strokes             | <input type="checkbox"/> Ankylosing spondylitis | <input type="checkbox"/> Ligament injuries  |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Psoriatic arthritis    | <input type="checkbox"/> Cartilage injuries |
| <input type="checkbox"/> A pacemaker         | <input type="checkbox"/> Reiter's arthritis     | <input type="checkbox"/> Osteoarthritis     |
| <input type="checkbox"/> An aneurysm         | <input type="checkbox"/> Spinal trauma          | <input type="checkbox"/> Dizziness          |

7. Have you seen another therapist before? Yes / No \_\_\_\_\_

8. If YES was there anything you were not happy about? \_\_\_\_\_

\_\_\_\_\_

9. What aspects were you happy with? \_\_\_\_\_

\_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Occupational Therapists Signature: \_\_\_\_\_

***“Thank you for your time taken to complete this form.”***

## **OFFICE POLICY**

Our goal is to deliver an exceptionally friendly and prompt, professional service providing you with the best in Occupational Therapy care. Our experience tells us that there are some key areas we need to focus on to ensure that you receive the **greatest benefit** from our services.

**Mobile Phones:** Out of respect for others, please turn off your mobile phone.

**Recovery:** Remember that healing and recovery takes time and not everyone heals/recovers at the same rate. If at any time during your care, you do not feel that you are responding as well as expected we would ask that you discuss this with your Occupational Therapist. We want you to get the most from your care at *The Wellness Place*.

**Excellence in Occupational Therapy:** In order to continue to provide the best, most up to date Occupational Therapy care available we travel periodically to conferences and seminars. To keep your progress on schedule we will attempt to book your appointments around those times or else provide another highly qualified Occupational Therapist to continue your care.

**Fees and Your Account:** Fees for private patients are due at the time of service. HICAPS and EFTPOS facilities are available at the front desk for automatic claiming through your private health fund. Workcover and DVA patient accounts will be sent directly to the appropriate body.

**Referrals:** The greatest compliment we can receive is the referral of a friend or family member. The referral of your family and friends is much appreciated as it will both sets them on the road to recovery and wellbeing and plays a vital role in the success of our business.

**Appointment Scheduling:** Your Occupational Therapist will outline a recommended action plan as the best plan for your injury. You will achieve the maximum results when you keep your recommended action plan to this schedule. Therefore, to receive the most out of your care and to save time we ask that you schedule your appointments in advance.

**Missed Appointments:** Missed appointments will set you back in your recovery, so we ask that wherever possible you keep all your appointments. If an appointment must be changed, 24 hours notice is appreciated. If less than 24 hours notice is given for a cancellation, a cancellation fee may be charged. Consideration will be given for unavoidable circumstances. All missed appointments must be made up later in the same day or within 24 hours to avoid a cancellation fee. **This fee is not covered by compensable bodies and must be paid by the patient.** People who repeatedly miss or reschedule appointments will regretfully be discharged from care as we realise you will not reach your health goals and we do not wish to waste your time.

I have read and fully understand the above Office Policy Form

Signed \_\_\_\_\_

# Informed Consent Form

Occupational Therapy treatment is generally an effective and safe form of treatment however like any treatment there are benefits and risks. The purpose of this form is to let you know what your rights are and how we address the issue of a collaborative decision making and informed consent between Occupational Therapist and patient.

Occupational Therapists in this practice will discuss your condition and options for treatment with you so that you are appropriately informed and can make decisions relating to treatment. You may choose to consent or refuse any form of treatment for any reason including religious or personal grounds. Once you have given consent, you may withdraw that consent at any time.

*Please read and sign the following:*

## **Questions of a personal nature**

Your Occupational Therapist may ask personal questions relating to your injury and how your injury impacts on your 'activities of daily living'. The more information you provide, the more likely it is that the Occupational Therapist can provide effective treatment. It is your choice as to what information you choose to provide. If you feel uncomfortable with a particular question or group of questions, please let the Occupational Therapist know and they will cease.

## **Physical contact**

During the examination, assessment and treatment it may be necessary for your Occupational Therapist to make physical contact. Your Occupational Therapist will ask your permission before making physical contact with you in any way. Wherever possible, contact will be made using a towel or other forms of screening. Physical contact requires your express consent. You may withdraw consent at any time at which point, all physical contact will cease immediately. Please inform your Occupational Therapist if you feel uncomfortable at any time.

## **Risk related to treatment**

As with all forms of treatment, there are risks and benefits. The Occupational Therapist will discuss any foreseeable risks with you prior to administering treatment. In some cases, the Occupational Therapist may ask you to read information related to a particular treatment and they may request that you sign a further consent form. This is to ensure that you fully understand any risks involved. You may withdraw your consent at any time even if you have previously signed a consent form.

## **Children and minors**

Consent from a custodial parent is required to treat a minor

## **Substituted Consent**

Where a person is incapable of understanding the risks and benefits of treatment, consent may be provided by another person legally authorized to provide such consent. Evidence of legal authorization is required in such circumstances.

## **You need to let us know**

The risk related to some treatments can increase if the Occupational Therapist is not aware of certain facts. Please inform the Occupational Therapist if you have

- A pacemaker or heart condition
- Suffered from blood clots, thrombosis or stroke
- Suffer from diabetes
- Are currently taking medication

I \_\_\_\_\_ [full name] have read and understood the above statements relating to consent for treatment. I offer my consent to receive treatment within the practice. I agree to this consent remaining valid until such time as I withdraw my consent.

Signed \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_