

Mr  Mrs  Miss  Ms  Dr  (tick applicable)

Surname: \_\_\_\_\_ Given Names: \_\_\_\_\_

Address: \_\_\_\_\_ Postcode \_\_\_\_ \_

Telephone Home: (\_\_\_\_) \_\_\_\_\_ Mobile/work: \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Occupation: \_\_\_\_\_

Email: \_\_\_\_\_@\_\_\_\_\_ Local Dr: \_\_\_\_\_

**Next of Kin:**

Mr  Mrs  Miss  Ms  (tick applicable) Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Ph (H): (\_\_\_\_) \_\_\_\_\_ (M): \_\_\_\_\_

**MEDICAL INFORMATION:**

*Please tick if you have or have had any of the following:*

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Cardiac pacemaker                             | <input type="checkbox"/> Hearing aid    |
| <input type="checkbox"/> Metal implant  | <input type="checkbox"/> Heart ailment                                 | <input type="checkbox"/> Epilepsy       |
| <input type="checkbox"/> Stomach ulcer  | <input type="checkbox"/> Allergic reaction to drugs/tapes/creams _____ |   |
| <input type="checkbox"/> High/Low Blood Pressure                                | <input type="checkbox"/> Cancer  | <input type="checkbox"/> Skin Disorders |
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Blood Clots                                   | <input type="checkbox"/> Depression     |
| <input type="checkbox"/> Other relevant medical history? (please specify) _____ |  |   |

Recent surgery (< 2 yrs): Yes  No  If 'Yes', please specify \_\_\_\_\_

Any serious illness: Yes  No  If 'Yes', please specify \_\_\_\_\_

Are you pregnant? Yes  No

**REASON FOR VISIT**  low back  neck  knee  shoulder  mid back  hip  ankle  
 foot  wrist  hand  hamstring  elbow  calf  other \_\_\_\_\_

**REFERRAL SOURCE-How/why did you come to THIS clinic?**

- Social media: (which?) \_\_\_\_\_
- Google/web browser search: (which?) \_\_\_\_\_
- Website  Yellow Pages
- Referred by Health Professional: (who?) \_\_\_\_\_
- Family/friends recommendation: (who?) \_\_\_\_\_
- Live nearby  Signage
- Sports Club Affiliation: (which?) \_\_\_\_\_
- Other: (please specify) \_\_\_\_\_

Would you like to receive a free copy of our quarterly newsletter?  Yes  No

# REGISTRATION FORM

## **WORKSAFE (Injured at work)**

*Please ensure correct details and Doctors referral is presented. Please request our clinic's WorkSafe Policy to inform you of your payment responsibilities.*

Employer's Name: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Postcode: \_\_\_\_ \_

Supervisor or contact person for WorkSafe Claim: \_\_\_\_\_

His/Her Telephone No: (\_\_\_\_) \_\_\_\_\_

Date of injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ Claim Number (if known): \_\_\_\_\_

Employer's insurance Company: \_\_\_\_\_

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## **TAC (Injured in motor vehicle accident)**

*Please ensure correct details and Doctors referral is presented. Please request our clinic's TAC Policy to inform you of your payment responsibilities.*

Claim Number (if known): \_\_\_\_\_ Date of accident: \_\_\_\_/\_\_\_\_/\_\_\_\_

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## **PRIVATE (Insured/Non-insured)**

*You will be required to settle the account in full after each consultation.*

Do you have private health insurance? (please tick applicable) Yes  No

If yes, please give name of insurer: \_\_\_\_\_

Do you have extra cover for Physiotherapy? (please tick applicable) Yes  No

Do you have extra cover for Remedial Massage? (please tick applicable) Yes  No

Name of person responsible for payment of account:

Mr  Mrs  Miss  Ms  Name: \_\_\_\_\_

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The above information is confidential and will not be shared with external parties.

By signing below,

I agree that the above information is correct, and that **if presenting with a WorkSafe or TAC claim I agree to pay an administration fee of \$15.00 per consultation.**

**SIGNATURE OF PATIENT** \_\_\_\_\_ **DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_  
(or Parent / GUARDIAN if under 16)

**NB Our clinic requires 24 hours notice for any cancellation/rescheduling of appointments. Late cancellations or missed appointments will incur a 50% charge of the scheduled fee.**