PLUS HEALTH COMPANY REGISTRATION & HEALTH SCREENING

Revised Feb 2022

Title:	Full Name:	*DOB and Age:
Postal Address:		Postcode:
Registered GP Practice:		Occupation:
Mobile Tel:		Email:
Name of Emergency Contact (and relationship to you):		Contact mobile number of Emergency Contact:
*Ethnicity:		**Just so you know…** The * marks in this assessment form relate to our covid secure risk assessment only.

Please answer the following and tick/detail as appropriate:	Yes	No
***Do you suffer from any respiratory conditions e.g. Asthma, COPD?** If yes, please list the condition, medication(s) taken and confirm whether it is well-managed/stable or unstable/requiring regular review. Please write details below:		
Do you have epilepsy? If yes, please list any medication(s) taken the date of your last seizure and confirm whether the condition is well-managed/stable or unstable/requiring regular review. Please write details below:		
Are you diabetic? If yes, please list the type (type 1 or type 2), any medication(s) taken and confirm whether it is well-managed/stable or unstable/requiring regular review. Please write details below:		
***Do you have heart, kidney or liver problems?** If yes, please list the name of the condition, medication(s) taken and confirm whether it is well-managed/stable or unstable/requiring regular review. Please write details below:		
Do you suffer from or have you previous had any circulatory disorders e.g. varicose veins, thrombosis, atherosclerosis, high blood pressure, low blood pressure, haemophilia? If yes, please list the name of the condition, medication(s) taken and confirm whether it is well-managed/stable or unstable/requiring regular review. Please write details below:		
***Have you had or do you currently have any major illnesses such as cancer?** If yes, please list the area(s) affected, year diagnosed, the form (if known), how it was/is being treated and whether you are still under review. Please write details below:		
Do you have a mental health issue such as anxiety or depression? If yes, please list the condition, when you were diagnosed (year) and any treatment to date (including medication, talking therapy). Please write details below:		

Client name and DOB:	YES	NO
Do you a thyroid problem? If yes, please list the condition (hypo/hyperthyroidism), medication(s) taken and confirm whether it is well-managed/stable or unstable/requiring regular review. Please write details below:		
Do you regularly feel lethargic, fatigued or excessively tired? If yes, please state whether this has been investigated (and when), if a cause has been established and how it is being managed (ie vitamin supplementation). Please write details below:		
Have you been investigated for or diagnosed with a vitamin D deficiency? If yes, please list when you were investigated (month/year), if you were found to be deficient and what medication (and dose) you are taking to manage this condition:		
Have you been diagnosed with or investigated for Osteoporosis or Osteopenia (brittle bones)? If yes, please list when you were investigated (year), if you were diagnosed as osteo*porotic* or osteo*penic,* whether you have had any related fractures and what medication you are taking to manage this condition:		
Have you ever had any fractures/broken bones? If yes, please list the location(s), whether surgery was required and if instrumentation was used (ie metalwork). Please write details below:		
Do you suffer from Osteoarthritis (OA)? If yes, please list the location(s), medication(s) taken and the approximate date of any xrays/scans. Please write details below:		
*Have you been diagnosed with or investigated for a neurological condition such as MS, parkinsons or stroke? If yes, please list the condition, medication(s) taken and confirm whether it is well-managed/stable or unstable/requiring regular review. Please write details below:		
*Do you have a condition which means you have a high risk of contracting infections? (ie sickle cell)		
Do you regularly fall, trip or lose balance? If yes, please give some details (including the date, location and any injuries sustained) about your last incident below:		
Do you have a history of spinal problems e.g. neck/upper/lower back pain, whiplash, scoliosis? If yes, please list the area(s) affected, whether you have had any x-rays or scans, any treatment to date (ie previous physio/injections etc) and whether it is a current issue. Please write details below:		
Do you suffer from pins & needles sensations or numbness? If yes, please list the area(s) affected, whether the cause has been established and if you are taking any medication to help manage this. Please write details below:		

Client name and DOB:	YES	NO
Have you had any major operations or are you awaiting any surgical procedures? (ie joint replacement surgery, cancer related ops, hysterectomy, arthroscopy) If yes, please list the surgery and the month/year as well the reason for it. Please write details below:		
Do you have any allergies ie. Latex/plasters? If yes, please list your allergies and any medication(s) taken to manage these. Please write details below:		
Do you suffer from any skin disorders e.g. eczema/psoriasis? If yes, please list your allergies and any medication(s) taken to manage these. Please write details below:		
*Women only: If you have had biological children, please state the age range of your child/ren and whether you have any issues with your pelvic floor (such as continence/prolapse/urgency). Please also state whether you could be pregnant:		
Do you regularly sleep (uninterrupted) between 6-8 hours / night? If no, please state the reasons why below:		
*Do you have a BMI of over 40? (clinically obese)		
*Have you had your full covid vaccination? If yes, please date month/year of second dose below:		
Please list all current medications below:		

Health Disclaimer:

By signing below, you are confirming you have given a true and thorough account of your health on this form and understand it is your responsibility to inform staff at Plus Health Company if there are any changes to your health, given they may affect your assessment, treatment and management options. You also agree to bring anything you are likely to need in order to optimally manage any known health conditions (ie inhaler for asthmatics) for all your attendances at Plus Health Company:

Signed:	Print:	Date:

Covid – 19 Compliance:

By signing below, you agree to fully comply with government guidance in relation to covid-19 and accept there is a risk you could contract covid-19 by attending an in person class or appointment. You are also confirming you are familiar with the protocols and requirements for accessing studio-based classes and/or face to face physiotherapy appointments, agree to adhere to these and will ask for further clarification on any aspect of your care as the need arises.

Signed:	Print:	Date:

Terms and Conditions/Privacy Policy:

By signing below, you are confirming you have read, understand and agree with our terms and conditions, as well as our privacy policy:

Signed:	Print:	Date:

Client name & DOB:

We'd like to know about your problem area(s) so please answer the following in as much detail as possible:

What is the presenting condition? (ie back pain)	
How and when did symptoms begin?	
Is there a history of trauma? If yes, please briefly detail what happened.	
Did it start suddenly or gradually?	
Are your symptoms constant, frequent or intermittent?	
How would you rate your pain at worst, on a scale of 0 to 10? (0 = no pain, 10 = worst imaginable)	
How would you rate your pain at best, on a scale of 0 to 10? (0 = no pain, 10 = worst imaginable)	
Are you managing to sleep uninterrupted or are you being woken by your symptoms?	
Is there a certain time of the day when your symptoms feel to be at their worst? If yes, when is this?	
What makes your symptoms worse? (ie specific activities/movements)	
What can you do to ease/relieve your symptoms? (ie medication, certain positions/exercises)	
Do you have any of the following symptoms? Circle as appropriate. **Please get in touch with us by telephone at your earliest opportunity if you experience any of these symptoms.**	

Unexplained weight loss	Severe Night Pain or Sweats	Dizziness
Pins and Needles/Tingling	Unable to control bladder/bowel	Changes in sensation around front or back passage
Numbness	Changes to Vision (tunnel, blurred, double)	A sudden fall for no apparent reason (drop attack)
Weakness in the Limb(s)	Slurred Speech	Difficulty finding words

List all the things you've tried to help yourself so far.	

Client name and DOB:	
Are you independent with your personal care at present? (ie washing, dressing, cooking etc)	
Are you undertaking all your normal activities besides? (ie work, hobbies and interests). Please give details.	
How are you feeling from a mental health perspective?	

PSFS: To help us make the most of your physiotherapy sessions with us, it would be helpful if you could identify up to 3 important activities which you are currently having difficulty with or are unable to do as a result of your current problem(s). Please list these below and score your level of ability between 0 -10 by highlighting the number applicable:

Activity 1:										
0	1	2	3	4	5	6	7	8	9	10
Unable to perform activity									Able to perform the activity at the same level as before the injury or problem	

Activity 2:										
0	1	2	3	4	5	6	7	8	9	10
Unable to perform activity									Able to perform the activity at the same level as before the injury or problem	

Activity 3:										
0	1	2	3	4	5	6	7	8	9	10
Unable to perform activity									Able to perform the activity at the same level as before the injury or problem	

If you have any specific questions or any other comments to add, please write these below and we can chat through them at your consultation:

Obtaining Your Consent for Assessment and/or Treatment

For consent to be valid, it must be voluntary, informed and the person giving it must have the capacity to make the decision. Here is a definition of each of these components:

- **Voluntary consent** means to decide freely and without being persuaded or pressurised by family, friends or professionals.

- **Informed consent** means that you have been provided with sufficient information to reach a decision. You should be presented with your options objectively (for instance, the potential benefits and risks of certain treatment options) and without bias. Your physiotherapist is likely to advise you based on evidence-based practice where possible but other alternative treatment options may also be offered alongside this.

- **Capacity** refers to your ability to use and understand the information presented to you in order to make a decision. Some examples of when an adult client may lack capacity may include: some mental health conditions, dementia, severe learning disabilities, brain injury, conditions which cause confusion or drowsiness and when intoxicated with drugs or alcohol.

In relation to Covid-19, we are required to specifically seek consent from you in relation to the potential risks of attending an in person physiotherapy appointment. Please read the following links which have been taken from the WHO (world health organisation) website:

https://www.who.int/health-topics/coronavirus#tab=tab_1

We have a professional duty to ensure we always obtain your consent during your consultation. We will endeavour to maintain best practice principles and will encourage you to ask us your queries and/or questions along the way.

When you give specific permission for us to do something (such as to palpate/touch a body part to help with our assessment) you are giving us your **express consent.** This can be given verbally or in writing. It is also likely you will give us your **implied consent** during your consultation. For instance, when partially undressing to aid assessment/treatment, you are giving your implied consent for us to assess/treat you. If we feel you are unclear about any aspect of your consultation, we will endeavour to provide you with additional information. **It is important that you know you have the right to withdraw your consent at any time, without reason, and we respect your decision without prejudice.**

By signing below, you are confirming you understand the information detailed above and accept there is a risk you could contract covid-19 by attending an appointment.

Name	Signature	Date

Thank you for completing this paperwork. It will enable us to be as thorough as possible when undertaking your assessment and formulating a treatment/management plan.

Please print, complete and bring this document with you to your initial consultation.