PHYSIOTHERAPY CASE HISTORY FORM

To help us prepare for your ***TELEHEALTH*** appointment, we need some information about how you are currently feeling and managing your health condition, as well as information about your history. This information will help us get a thorough understanding of your medical history and presenting complaint and the difficulties you are experiencing. It will also allow us to provide the most accurate assessment and treatment during your ***TELEHEALTH*** appointment.

PLEASE COMPLETE THE FOLLOWING QUESTIONS AS FULLY AND ACCURATELY AS POSSIBLE

PERSONAL DETAILS

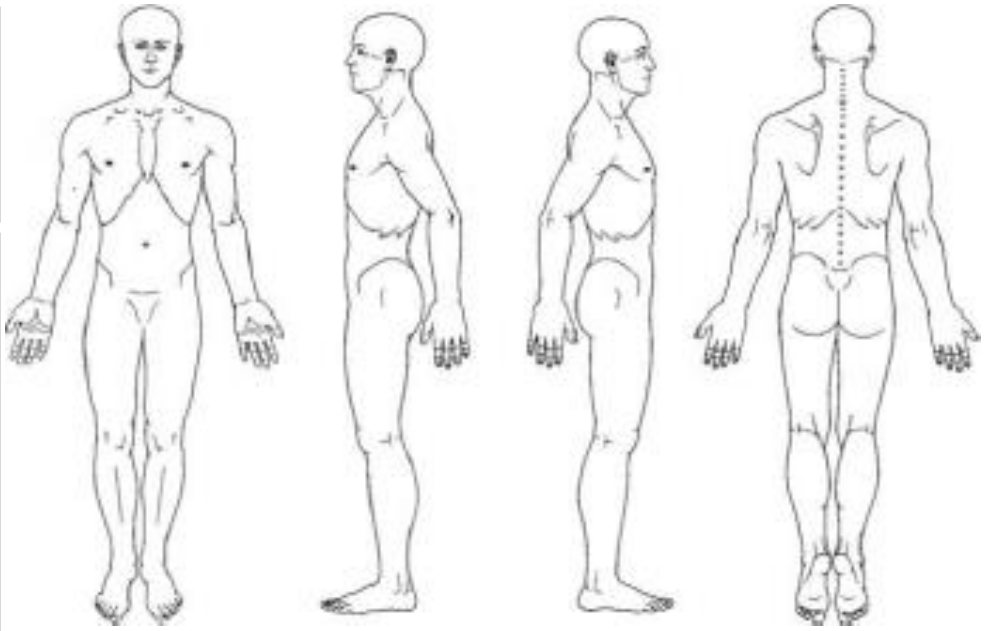
Name:	Date of Birth:	Date:
Sex: Male ☐ Female ☐ Other ☐	Parent/Guardian Name (if applicable):	
Phone Number (home):	Phone Number (mobile):	
Address:	Email:	
Primary Language Spoken:	Other Languages Spoken:	

Please Tick if you identify as any of the following:

Aboriginal ☐ Torres Strait Islander ☐ Refugee ☐ Non-English-speaking background ☐

REASON FOR CONCERN

Please select your area(s) of pain by adding a 'sticky note' these images



Please tick the appropriate response below

Is your pain…

Deep ☐ Superficial ☐

Intermittent ☐ Constant ☐

Sharp ☐ Shooting ☐

Burning ☐ Stinging ☐

Throbbing ☐ Diffuse ☐

Do you have any:

Pins & Needles YES ☐ NO ☐

Numbness YES ☐ NO ☐

Tingling YES ☐ NO ☐

Have you ever experienced any of the following:

Clicking ☐ Locking ☐ Popping ☐ Grinding ☐ Giving way/Feeling unstable ☐

If YES – please provide details:

Please describe your primary concern(s):

BEHAVIOUR OF SYMPTOMS

When did your primary concern start/was there a known cause?	Was the onset slow or sudden?
Have your symptoms changed since they first occurred?	Do you have other symptoms elsewhere in the body?

On a scale of 0 (no pain at all) to 10 (worst pain imaginable), what is the intensity of your concern? Please tick a number below.

At rest: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

At best: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

At worst: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

With regards to this concern, how do your symptoms change throughout the day?	A.M. (First waking)	
	Throughout the day	
	Night time (end of the day, sleeping)	

What is the degree your symptoms restrict movement and function?

What movements and activities increase your symptoms?	What movements and activities ease your symptoms?

When your symptoms are **increased**, how quickly do they come on and how long do they take to ease? For example, *it takes 20 minutes of walking on flat ground for my symptoms to increase to a 5/10 pain, and then it takes approximately 4 hours for the symptoms to ease/settle*.

Have you had any investigations performed relating to your concern? (e.g. x-rays, MRI, blood test) If so – where? Can you provide copies of the reports or images?

Have you previously injured this are of concern? If so – please provide the details of any treatment received.

MEDICAL HISTORY

Name of GP:		Phone:		
Address:				
Please list any past medical history details:				
Do you suffer from any of the following medical conditions?	Thyroid problems	YES ☐ NO ☐	Heart conditions	YES ☐ NO ☐
	Rheumatoid conditions	YES ☐ NO ☐	Epilepsy	YES ☐ NO ☐
	Asthma/Respiratory conditions	YES ☐ NO ☐	Diabetes	YES ☐ NO ☐
	Steroid use/ Osteoporosis medication	YES ☐ NO ☐	Other:	YES ☐ NO ☐
If you answered YES to any of the above, please provide details:				
Do you have any of the following?	Unexplained weight loss	YES ☐ NO ☐	Age > 55 or <20 years old	YES ☐ NO ☐
	Constant, unremitting pain	YES ☐ NO ☐	Widespread pins & needles/ numbness/tingling	YES ☐ NO ☐
	History of cancer	YES ☐ NO ☐	History of trauma	YES ☐ NO ☐
	Thoracic pain with any obvious cause	YES ☐ NO ☐	Recent bladder/bowel changes	YES ☐ NO ☐
	Pins & needles or numbness in the saddle region	YES ☐ NO ☐	Difficulty swallowing	YES ☐ NO ☐
	Difficulty speaking	YES ☐ NO ☐	Unexplained fainting episodes	YES ☐ NO ☐
	Double vision	YES ☐ NO ☐	Dizziness	YES ☐ NO ☐
Please list any allergies you have:				
Please list your current medications:				

SOCIAL HISTORY	
Please describe your living situation	
Does where you live have stairs? If so, how many?	
Do you currently need assistance to complete household tasks?	
What is your occupation? If you are not working – is this due to your current symptoms?	
Do you currently require a walking aid?	
Prior to the onset of your symptoms, did you need a walking aid?	
How much exercise are you currently doing?	
How much exercise were you doing previously?	
What are your hobbies/interests?	
GOALS	
What do you want to achieve through Physiotherapy?	
What do you expect from your Physiotherapy session?	
How long do you expect it will take to achieve your goals?	

CONSET

Consent to provide a CQUniversity Physiotherapy Service

I consent to a CQUniversity Physiotherapy Telehealth Consultation with a Physiotherapy student at the student led clinic, supervised by a fully qualified Physiotherapist Clinical Supervisor.

YES ☐

Consent to use personal details

I consent to my details to be collected as part of the service and acknowledge they may be used and disclosed for the purpose of assessment and treatment.

I consent for my personal details to be used for the teaching and clinical learning of the students along with academic research

I acknowledge that my personal details will not be provided to external parties without my consent. I will be asked for consent should correspondence need to be sent to other professionals.

YES ☐

Patient name:		Date of birth:	
Parent/guardian name: (if applicable)			
Signature:		Date:	

Thank you for taking the time to complete this form.

We look forward to your upcoming Telehealth appointment.

Please return this form via email.