GOLD COAST SPORTS MEDICINE AND REHABILITATION

Patient Consent Form

Name: _____ _____
(First) (Last)

Address: _____

City: _____ State: _____ Post Code: _____

Mobile: _____ Home Phone: _____

Email: _____

Gender: M F Other DOB: _____

Occupation: _____

Emergency Contact Name / Phone: _____

GP Name / Location: _____

Funding: Private Y N Health Fund: _____

DVA Y N NDIS Y N

CHSP Y N HCP Y N

How did you hear about us: _____

Online: Google Facebook Instagram

Medical: Doctor Specialist Other

Friend Family Are you happy to tell us who so we can thank them?

Please tick YES or NO for the following:

YES	NO	
☐	☐	Diabetes
☐	☐	Asthma, COPD, COVID or respiratory conditions
☐	☐	Epilepsy or Seizures
☐	☐	Neurological Disorders, Anxiety, Depression
☐	☐	High Blood Pressure
☐	☐	Heart Disease
☐	☐	Do you smoke
☐	☐	Are you pregnant
☐	☐	Broken bones, sprains, dislocations
☐	☐	Arthritis - Osteoarthritis, Rheumatoid, Juvenile
☐	☐	Recent surgery, or hospitalisation
☐	☐	Headaches, migraines, concussion

Medications: _____
_____
_____
_____

Medical / Surgical History: _____
_____
_____
_____

Sports / Activities: _____
_____
_____
_____

Consent to Treatment

I .....of sound mind make the informed choice to participate in an ongoing therapy program conducted by Gold Coast Sports Medicine and Rehabilitation. I understand all that is written on this document and have given an honest and complete account of my history. I consent to assessment, treatment, and the possible use of videography for assessment and treatment purposes only.

Confidentially

I agree to grant permission for Gold Coast Sports Medicine and Rehabilitation to disclose, where reasonably necessary, any required medical and personal information to third parties including: general practitioners, other physiotherapists, hospitals, insurance agencies acting on your behalf and other health professionals in the event that reasonable information is required in an attempt to provide for my optimal health and physical progression.

Name: _____ Date: _____

Signature: _____

Parental / Guardian Consent: _____
(For patients under 16)