|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **NAME**  **ADDRESS**  **DOB**  **Please note no under 16’s accepted.** | | **GP NAME**  **GP SURGERY** | | | |
| **Phone numbers** | | **Can we leave a message at these numbers?**  **Yes No** | | | |
| **Home** |  |  | |  | |
| **Work** |  |  | |  | |
| **Mobile** |  |  | |  | |
|  | |  | |  | |
| Do you need an interpreter?  If yes which language? | | **Yes** |  | **No** | **n** |

Please give a description of why you want a Physiotherapy assessment:

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| How long have you had this complaint? (please enter number of) | | | | | | | | |
| Days |  | Weeks |  | Months | |  | Years |  |
|  | | |  |  |  | |  |  |
| Is this problem | | | New |  | Ongoing? | |  |  |
|  | | | |  | |  |  |  |
| Are the symptoms worsening? | | | | Yes | |  | No |  |
|  | | | |  | |  |  |  |
| Are you able to carry out your normal activities? | | | | Yes | |  | No |  |
|  | | | | | | | | |
| Are you off work/unable to care for a dependant because of this problem? | | | | | | | | |
| Yes |  | No |  | Not applicable | | |  |  |
|  | | | | | | | | |
| If you have back pain with leg pain, have you had any changes in your bowel or bladder habits involving urgency or frequency or any numbness between your legs? | | | | | | | | |
| Yes |  | No |  | If yes, please give details. | | | | |
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| Have you suddenly lost any weight without trying? | | | | | | | | |
| Yes |  | No |  | If yes, please give details. | | | | |
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| Have you had any other symptoms, such as numbness, tingling or muscle weakness? | | | | | | | | |
| Yes |  | No |  | If yes, please give details. | | | | |
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Date form completed: