**PLEASE COMPLETE ALL 6 PAGES PRIOR TO FIRST APPINTMENT**

**TEMPORARY COVID-19 PROCEDURES**

Due to government and medical guidelines we have to change the way we do things to keep patients and staff safe.

**1) VIRTUAL FIRST APPOINTMENT**

- We are obliged to operate a virtual first phone appointment system. This can be just prior to seeing the physiotherapist face to face.

Please do not book a face to face appointment if you feel unwell with COVID 19 symptoms or are clinically vulnerable.

**2) PATIENTS WILL NEED TO SIGN A COVID-19 CONSENT FORM PRIOR TO ATTENDING FOR A FACE TO FACE APPOINTMENT**

- All patients attending for face to face appointment must sign the consent form below. Please complete this form and e mail to [adam@newforestphysio.co.uk](mailto:adam@newforestphysio.co.uk) PRIOR to your first appointment.

**3) PATIENTS NEED TO WEAR FACE MASKS AND USE HAND SANITISER DURING THEIR APPOINTMENT**

**4) PATIENTS TEMPERATURE WILL BE TAKEN PRIOR TO FACE TO FACE APPOINTMENT**

- If you have a high temperature (above 37.8’) you should self isolate for 10 days or get a COVID 19 test. Your appointment will be rescheduled.

**5) THE PHYSIOTHERAPIST WILL BE WEARING PPE**

**6) ARRIVE AT APPOINTMENT TIME, PLEASE DO NOT ARRIVE EARLY**

- At Solent Business Centre knock and wait outside Unit 413 on the 4th floor.

- At Forestside Medical Practice wait in your car in the car park at the rear of the building. If you are on foot wait by the fire exit at the rear of the building. Please do not enter the practice main entrance.

**7) MAINTAIN SOCIAL DISTANCING WHEN OUTSIDE TREATMENT ROOM**

**8) TREATMENT ROOM IS CLEANED WITH DISINFECTANT BETWEEN EVERY PATIENT**

- Please only touch the treatment plinth and plastic box for belongings during treatment.

**9) PLEASE ATTEND YOUR APPOINTMENT ALONE**

**-** If you require a chaperone please tell your physio at the phone consultation.

Thank you for your co-operation during this difficult period.

Kind regards

Adam Smith-Connor

**PHYSIOTHERAPY CONSENT FORM DURING COVID-19 PANDEMIC**

1. Have you had any COVID 19 symptoms in the last 14 day: fever, shortness of breath, loss of sense of taste or smell, dry cough, runny nose, headaches, sore throat?

Yes ⬜ No ⬜

1. Have you been advised to shield at home by the NHS?

Yes ⬜ No ⬜

1. Have you been in close contact with anyone with confirmed COVID-19 in the last 14 days?

Yes ⬜ No ⬜

1. Can you wear a face covering and use hand sanitiser during your appointment?

Yes ⬜ No ⬜

1. Have you had the COVID 19 vaccine?

Yes ⬜ No ⬜

1st injection date:……………..

2nd injection date:……………

1. I am aware that my physiotherapist may have to postpone my appointment at short notice if they develop COVID 19 symptoms or if they come into close contact with someone with confirmed COVID 19 within 14 days of my appointment.

Yes ⬜ No ⬜

1. I am aware that my physiotherapist is obliged by government guidelines to manage my condition remotely and will only book a face to face appointment if absolutely necessary.

Yes ⬜ No ⬜

1. I agree to attend a face to face appointment during the COVID-19 pandemic.

Yes ⬜ No ⬜

Patient / Guardian Signature: …………

Date: ………..

Physiotherapist Signature: ……Adam Smith-Connor…………………….

Date: …………

**Health Check List**

Please complete this health-screening questionnaire, which will help us to assess your needs.

Do you suffer from any of the following conditions / symptoms?

**Delete as appropriate (If yes please provide full details below)**

Diabetes (Type I or type II) Yes No

Epilepsy Yes No

Headaches or migraine Yes No

Heart conditions (eg angina, heart attack, heart murmur) Yes No

Lung conditions (eg asthma, bronchiectasis, COPD, tuberculosis) Yes No

Haemophilia / taking blood thinners Yes No

Cancer Yes No

HIV Yes No

Bone Conditions (eg osteoporosis, RA) Yes No

High blood pressure Yes No

Low blood pressure Yes No

Back pain Yes No

Muscle, nerve or joint problems Yes No

* E.g. arthritis, repetitive strain injury,
* Recurrent injuries, carpel tunnel syndrome

Stroke or head injury Yes No

Genetic disorders (eg cystic fibrosis, muscular dystrophy) Yes No

Neurological conditions (eg MS, Guillain Barre syndrome) Yes No

Unexplained weight loss Yes No

Abnormal bowel or bladder function (E.g. constipation/diarrhoea/urinary incontinence/retention)

Yes No

Muscle Weakness (E.g. dropping things/dragging your feet) Yes No

Difficulty Speaking (E.g. slurred speech, difficulty finding the right words) Yes No

Double Vision Yes No

Mental health problems (eg. depression, anxiety) Yes No

Dizziness, labarynthitis or vertigo Yes No

Are you currently pregnant / think you might be pregnant? Yes No N/A

Have you fractured any bones in the past? Yes No

Do you have any metal implants Yes No

Do you have a pacemaker Yes No

Do you suffer from any allergies Yes No

Please list any operations you have had with dates.

Please list all your current medications (including blood thinners and steroids).

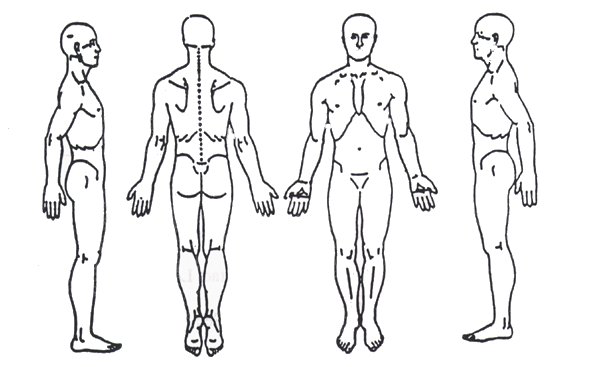
Please use this space to list any other conditions, not already mentioned above.

Please explain the reason for your visit (e.g. back pain/unable to reach up, etc.)

Where does your pain occur? (Please mark on the diagram below with an ‘X’)

Please score each area of pain (on the diagram) from: 0 (No pain) to 10 (Extreme pain)

Please mark on the any areas of numbness or pins and needles with an ‘O’



When did this pain begin? Please provide approximate date.

What caused your pain? (E.g. Car crash, fall, repetitive movement, sport, unknown, etc.)

What activities worsen the pain? (E.g. bending, heavy lifting, sneezing, reaching up, etc.)

What relieves your pain? (E.g. Pain killers, hot water bottle, stretching, etc.)

Have you had any previous treatment for this problem? (If yes, please provide details below)

Please rate your pain on severity from 0 (No pain) to 10 (Extreme pain), at these different times of the day: (Please circle)

Morning

0 1 2 3 4  **5** 6 7 8 9 10

Afternoon

0 1 2 3 4 5 6 7 8 9 10

Evening

0 1 2 3 4 5 6 7 8 9 10

Has the pain affected your sleep in any way? YES NO

Have you had any investigations into your pain? YES NO

(E.g. X-Ray, MRI scan, ultrasound, blood test, etc. If yes, please provide details below)

What do you do for a living?

List any regular sports or hobbies you do