Patient Questionnaire

1. **Practitioner:** Physio ☐ Bio ☐ Other ☐
   - Title:
   - Name:
   - Tel number:
   - Address:
2. **Basic information of patient:**
   - Title:
   - Name:
   - Date of birth:
   - ID number:
   - Occupation:
   - Referring person:
   - Tel number:
   - Address:
3. **Have you had any orthopaedic/neuromuscular/musculoskeletal injuries? Please include the nature of the injury, and how and when it occurred.**

4. **Have you had any orthopaedic/neuromuscular/musculoskeletal surgeries?**

5. **Do you have any chronic injuries? If so, please describe the nature of the injury and for how long it has affected you.**

6. **Do you suffer from any of the following conditions?**

	Past	Present
• Foot & ankle	☐	☐
• Lower leg	☐	☐
• Knee	☐	☐
• Thigh	☐	☐
• Pelvic girdle	☐	☐
• Lower back	☐	☐
• Mid back	☐	☐
• Upper back	☐	☐
• Shoulder girdle	☐	☐
• Head & neck	☐	☐
• Other	☐	☐

7. **Have you had any past treatments? If so, how successful was the treatment?**

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8. **Did you suffer from any conditions that later progressed to a resultant condition? If so, please describe.**

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