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| --- | --- |
| **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: