**MUSCULOSKELETAL PHYSIOTHERAPY SERVICE**
**PATIENT ASSESSMENT QUESTIONNAIRE/SELF REFERRAL FORM**

Cornwall Partnership NHS
NHS Foundation Trust

Please complete **both** sides of this form before your Physiotherapy Assessment

| **Mr/Mrs/Miss/Ms/Dr/Other**<br>**Full Name:** | **Date of birth:** | **Gender: M F** |
|---|---|---|

Full Address:……

……...

Telephone Numbers: Home:…….Mobile:……..

GP Name/Practice:……

NHS Number:……Ethnicity:…….

Who recommended that you have Physiotherapy: GP □ Consultant □ Self □ Other □

Do you work for CFT □ RCHT □ If so, how did you hear about this service?

Briefly describe your current problem, e.g. *knee pain, fractured ankle (please note exceptions: 1. If you have a back or neck problem please see your GP who may refer you. 2. Patients under 16 years of age must be referred by a GP).*
When did it start and how long have you had the symptoms?

How did it start?

Is your problem: Getting better □ Getting worse □ Staying the same □

Using a scale of 0-10, score your level of pain, where 0 is no pain and 10 is the worst possible pain

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

Have you had any previous treatment for this problem? *(e.g. medical treatment, physiotherapy, osteopathy, chiropractor):* □ YES □ NO
If yes, please give details, including WHERE and WHEN:

Have you had any investigations for this problem? *(e.g. scans, X-rays, blood tests)* □ YES □ NO
*If yes, please give details:*

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**Name:** **NHS Number:** **Date of birth:**

**Your general health** – please tick if you have any of the following:

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Any major illness/health problem | | | Unexplained weight loss | | |
| History of cancer | | | Rheumatoid Arthritis | | |
| Diabetes | | | Epilepsy | | |
| Heart problems | | | Pregnancy (current) | | |
| Blood pressure problems | | | Any surgery/operations | | |
| Chest/breathing problems | | | Previous fractures | | |
| Steroids | | | Osteoporosis | | |
| Anticoagulants | | | Any other joint problems | | |
| Any bladder/bowel symptoms | | | | | |

***Please give details:***

Please list any medications that you are taking or bring a print out of your current prescription:

What is your occupation?:

Please give details of any hobbies:

Are you: Off sick due to this problem □ Employed □ Retired □ Main carer □
Self-employed □ Unemployed □ Student □ Other □

What do you think is causing this pain and how do you think that Physiotherapy will be able to help you?

**I……confirm that the information provided above is correct to the best of my knowledge. I give my consent to the physiotherapy assessment and treatment of my problem.** *(This may be withdrawn at any time during this period).*
**I am aware that I may be accompanied by a chaperone.**
**I am aware that I can ask for a copy of my letter**
**I give consent for a message to be left on my answerphone Yes/No**

Patient signature……Date……
Are you completing this form on behalf of someone? Yes/No
If so please state your name and relationship to this patient
Name……Relationship……..